THE PERCEIVED ROLE OF PHYSICIAN OFFICE HEALTH COACHES IN

DELIVERING CHRONIC CARE TO PATIENTS IN A PRIMARY CARE CLINIC

GROUP IN THE MIDWEST: A PHENOMENOLOGICAL QUALITATIVE STUDY


A dissertation submitted by

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Dedication

I wish to express appreciation to the faculty of College of Saint Mary for developing the Health Professions Education Emphasis Program for doctoral students. The guidance and support of my advisor Peggy Hawkins was instrumental in the completion of my doctoral study. This study is dedicated to my parents Lloyd and Mona Roberts and my brother David whose lives were cut short because of a lack of coordinated integrated healthcare. Finally, this work is also dedicated to my husband Timothy and children Emily and Lance who will benefit from a healthcare system that responds to the needs of communities it seeks to serve.

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ABSTRACT

Newly hired Physician Office Health Coaches (POHCs) were part of a system delivery redesign to improve patient centered care that utilized disease registries to expose care opportunities, adoption of standardized clinical standards, and use of health care teams to create new relationships with activated, empowered patients. The purpose of this study was to explore the perceived experiences of POHCs as they delivered quality chronic care to patients. Field research was conducted at seven primary care family medicine or internal medicine clinics within a clinic organization and consisted of seven interviews with POHCs. The research question was how do POHCs describe the experience of their role in primary care clinics' implementation of the Chronic Care Model? To interpret interview transcripts, NVivo software assisted analysis and themes emerged. By using the Transtheorectical Model of behavior change with motivational interviewing, POHCs assisted patients to explore their ambivalence, move toward positive goal setting, and learn skills necessary for self-management. Physician Office Health Coaches identified chronic care delivery opportunities by creating and maintaining a disease registry which in turn nurtured a relationship with patients. They utilized the techniques of motivational interviewing to assist patients in goal setting and

tracked patient progress through chart reviews. Acting as an extension of the doctor,

being an advocate for patients, and a resource for information were all roles for coaches.

The POHCs also challenged old ways of delivery to try new processes using PDSA

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CHAPTER I: INTRODUCTION

Purpose of the Study

The purpose of this phenomenological qualitative study was to explore the

perceived experiences of Physician Office Health Coaches (POHCs) as they delivered

quality chronic care to patients within a primary care setting in the Midwest. The field

research was conducted at seven primary care family medicine or internal medicine

clinics. The sample consisted of seven interviews with POHCs that were purposefully

selected by the Director of the Quality Improvement Committee who was responsible for

implementation of the clinic administration's quality improvement program and was part

of the group that started the POHC program. All participants were informed of the nature

and purpose of the study at the time the interview was scheduled and at the beginning of

the interview informed consent was obtained.

Context of the Problem

Physician Office Health Coaches delivered patient education and self-

management skill development as part of their interaction with chronically ill patients.

There is limited systematic documentation of the effects of self-management education

on patient health status (Lorig & Holman, 2003). Patterson (2001) called current self-

management education a myth of empowerment. "There was an underlying assumption

by many practitioners that an invitation for patients to participate equally in their health

care was sufficient to guarantee empowerment" (p. 574). Patient comments included statements that rushed appointments left little time for interaction and often their experiential knowledge was discounted (Blakeman, MacDonald, Bower, & Chew-Graham, 2006). The POHC with skills and time to assist patients can activate, educate and motivate those with which they interact. This study described POHC experiences and how prepared the coaches believed they were to assist and empower patients.

<div align="center">Research Questions</div>

The research questions evolved from the overarching question of what is the perceived role of the POHC and what is required of the POHC so they can accomplish their professional goals? These questions helped to understand the overall essence of the experience of being a POHC.

<div align="center">Delimitations</div>

Scope of this study was limited to POHCs employed within one primary care organization. The time period was October 2007 through August 2008. The first health coaches were hired in 2004 and were new to their positions at the time of hire. As they remain in their role, responses may change to the initial questions.

<div align="center">Limitations</div>

The ability to generalize results on the basis of this study was limited which is characteristic of qualitative studies. Creswell (2007) believed it might be better to consider "suspending our understanding in a reflective move that cultivates curiosity" (p. 62). The researcher's bracketing personal experience was done through journaling before, during, and after entry into the field. To gain access to the study group, the researcher spent time building trust and credibility with clinic administration. In group meetings it

was sometimes awkward as the researcher moved from nonparticipant to participant. During the interview process it was sometimes difficult to ask the appropriate questions and to rely on the POHC to be willing to discuss their experiences. The researcher was able to use interviewing experience, asking open ended questions, asking for clarification, and diving deeper into responses to better understand the POHC. In journaling, the researcher reflected on the relationship between the researcher and interviewee. It is important for the researcher to see themselves as a research instrument thinking about rapport and sensitivity to participants. The population of the study was all from one clinic organization as it was implementing the Chronic Care Model. It is not sure how long the changes would last or if implementation would be long-lasting. Over time the role of the POHC may evolve, especially with the adoption of electronic medical records and as preventive measures are added to disease registries. It was the purpose of the study to elicit understanding and not to test hypotheses.

<div align="center">Definition of Terms</div>

Attributes: A named value given to documents in NVivo such as gender "male" or
 numbers such as years as a healthcare worker.

Chronic Care Model: Chronic care oriented system that has the components of use of
 nonphysician team members, planned encounters, self-management for high risk
 patients and electronic registries. It is an organized approach to caring for people
 with chronic disease in a primary care setting.

Chronic Conditions: A chronic condition lasts a year or longer, limits what one can do
 and may require ongoing care. Examples of chronic conditions are diabetes,
 cancer, heart disease, and asthma.

Clinic Champion: Designated clinic physician who organizes and implements quality

improvement initiatives.

Clinical Guidelines: Evidence-based guidelines that utilize research data to provide

reliable and practical data to aid in decision making about a patient's care. Source

of guidelines National Guideline Clearinghouse www.guidelines.gov

Clinical Outcome Measures: Patient-level disease measures e.g. hemoglobin A1c, blood

pressure, lipoprotein levels.

Code (verb): The action of assigning passages of text from a document to a node. The

node is then said to code the passage.

Disease Registry: Database or storage of data on populations for use in individual care

and to track outcomes across the population. Summaries of care can be printed at

time of visit to expose opportunities for interventions.

Empowerment: Process in which a person gains mastery over his or her own affairs.

Health Coaching: Healthcare practitioners that assist people in reaching their best health

and well-being in combination with medical and disease management programs.

Interdisciplinary Team: Coordination of providers such as physicians, nurses,

pharmacists, social workers, therapists, dieticians, medical assistants, and

counselors that work together to best serve the needs of patients.

Medical Home: Patients select a provider for continuity of care. Disease management,

preventative procedures, and screenings are all coordinated by one provider.

Model for Improvement: Tool for accelerating quality improvement with two parts:

(a) Questions guide practice to set specific intended goal and measures change
ideas. (b) Use <u>P</u>lan-<u>D</u>o-<u>S</u>tudy-<u>A</u>ct (PDSA) cycles to test changes in the work
environment. See below under PDSA Cycles.

Motivational Interviewing: Client-centered counseling style for increasing intrinsic
motivation by helping clients explore and resolve ambivalence.

Node: An object in a project which represents anything in the project users wish to refer
to such as people being studied, places, interviews, documents, and features of the
research.

Nonphysician health care providers: health care professionals such as nurse practitioners,
physician assistants, registered nurses, medical assistants, and occupational
therapists.

NVivo coding: A code or process of coding in which a text section in a document
becomes the title of the node.

Pay for Performance: Compensation based on meeting targets or set goals.

PDSA Cycles: Model for continuous quality improvement that use the steps <u>P</u>lan-<u>D</u>o-
<u>S</u>tudy,-<u>A</u>ct to try a small scale change before implementing on a large scale. This
process was developed as a method to rapidly test a change (Transforming care at
the bedside toolkit Section 3 Chapter 3, 2008).

Population Based Care: System which identifies health problems within a specified
population defines evidence-based interventions for members of the
subpopulation and regularly monitors patient progress.

Quality Care or Quality Chronic Care: For the purpose of this study, Institute of Medicine

states quality care is care that is safe, effective, patient-centered, timely, efficient,

and equitable.

SMART Goal: Tool to set goals by making them Specific, Measurable, Attainable,

Realistic, and Timely.

Self-management: Refers to methods, skills, and strategies by which individuals can

effectively direct their own activities toward the achievement of objectives, and

includes goal setting and planning.

Shared Medical Visits: Ten or more patients seen at the same time come together to

discuss issues with their chronic disease. Physician Office Health Coaches review

charts before visits, draw labs, vitals, and billing is based on individually

delivered services.

Visual Coding: Practice of emphasizing passages of text by using rich text features (font

color) as a visual counterpart of coding at nodes.

CHAPTER II: REVIEW OF LITERATURE

Historical Context

Whether the focus was local, national, or global; affordable health care has been an issue facing all communities. Current systems fail to meet patient outcomes and have not delivered evidence-based care to the chronically ill (Anderson & Horvath, 2004; Eccles, McColl, Steen, Rousseau, Grimshaw, Parkin, & Purves, 2002). The Institute of Medicine (IOM) created in 1970 by the National Academy of Sciences, uses evidence based information and peer review as an advisor to the nation on health issues. In 2001 the IOM defined the situation as the chasm or gap between health care being delivered and care needed in communities (Institute of Medicine, 2001). According to the 2007 Improving Chronic Illness Care (ICIC) website, 133 million people or almost half of United States' citizens live with chronic conditions (ICIC, 2008). Chronic illness is now the major cause of disability and accounts for 70% of health care expenditures (Holman & Lorig, 2004). A reasonable assumption is that the number will increase as baby boomers age and increase in longevity (Wise, Bahl, Mitchell, West, & Carli, 2006). The current method of primary care delivery has been more aligned with acute care and has not met the needs of people living with comorbid chronic illness or the definition of quality care (Moore, 2006; Wagner, Austin, Davis, Hindmarsh, Schaefer, & Bonomi, 2001).

The deficiencies in the system included lack of coordination of care, lack of active follow-up or not having established clinical guidelines, and patients not trained to self-manage illnesses. McGlynn, Asch, Adams, Keesey, Hicks, DeCristofaro, & Kerr, (2003) found participants in the study received 54.9% of recommended care. The same study

stated the United States ranked 37th in the world in overall health system performance and 72nd in population health according to the World Health Organization World Health Report 2000. As many as 98,000 people die in any given year from medical mistakes and only half of the population received needed preventive care (Institute of Medicine, 1999). Having experienced preventable medical problems changed patient interactions with primary care and created anger, mistrust, and resignation. Elder, Jacobson, Zink, and Hasse (2005) interviewed patients and found responses divided into categories:

1. Avoidance or no longer coming in

2. Accommodation by learning to deal with delays

3. Anticipation by attending to details and personal emotions

4. Acquired knowledge about illness

5. Advocacy to push for treatments or obtain a second opinion.

The IOM in 2001 called for a sweeping redesign of the entire health system. *Crossing the Quality Chasm* states, "faced with such rapid changes, the nation's health care delivery system has fallen far short in its ability to translate knowledge into practice and to apply new technology safely and appropriately. Health care today harms too frequently and routinely fails to deliver its potential benefits" (p.1). The IOM's aims for the 21st century were six fold: safe, effective, patient-centered, timely, efficient, and equitable. Effectiveness of care for major illnesses such as diabetes, hypertension, congestive heart failure, depression, and asthma was enhanced with new clinical and behavioral interventions. To achieve the improvement aims, ten rules of redesign were formulated:

1. Care based on continuous healing relationships

2. Care customized according to patient needs and values

3. The patient is the source of control

4. Knowledge is shared and information flows freely

5. Decision making is evidence-based

6. Safety is a system property

7. Transparency is necessary

8. Needs are anticipated

9. Waste is continuously decreased

10. Cooperation among clinicians is a priority (p. 8).

Health care needed to respond to consumer preferences. According to Berry, Seiders, and Wilder (2003), patient-centered care had the characteristics of availability, appropriateness, preference, and timeliness. It was best understood as a philosophy rather than a particular set of techniques. The authors proposed utilizing all members of the health care team, including the patient, working up to their training, skills and expertise so as to increase outcomes and decrease costs. Teams utilized more nonphysician members, as well as patients and families engaged in care which increased outcomes for the underserved. Application of information technology utilized electronic medical records, telephone appointments, nonphysician appointments, group appointments, and on-line communications as innovative methods that engaged patients and conserved resources (Eccles, et al., 2002). Cooper and Fishman (2003) proposed the use of interdisciplinary teams to coordinate benefits while using the medical record as the vehicle to share information.

In 2007 Schoen, Osborn, Doty, Bishop, Peugh, and Murukutla, surveyed adult health care experiences in these seven countries: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. All major industrialized countries were implementing initiatives to seek improvement in performance, while delivering health care that was accessible, high quality, safe, and efficient. Patient views offered insight into experiences and opportunities to improve. This 2007 Commonwealth Fund International Health Policy Survey of Adults found although the United States spent the highest share of national income on health care, it was the only country which left a high proportion of the population uninsured or under protected in case of an illness. As many as one-fifth of United States adults reported problems paying medical bills which is double the rate of the next country. Respondents with multiple chronic diseases reported problems coordinating care and wanted more time spent with providers as well as being given treatment choices. Those with a "medical home" had more positive experiences with access and coordination of care, which was associated with lower rates of patient reported errors and appeared more patient-centered. In this study, the medical home was not system wide in any country.

A literature review by Clark and Gong (2000) revealed although there were advances in asthma treatment, morbidity and mortality were at an all time high. Goals to control symptoms, restore physical and psychological function, and eliminate interference with social relationships and quality of life were not met. A recommendation was made to base effective teaching more on findings of behavioral theory research. A systematic review and meta-analysis looked at effectiveness of educational programs for self-management of asthma in children. Programs for self-management had better

control, reduced absenteeism from school, less number of days with restricted activity,

and reduced number of emergency room visits (Guevara, Wolf, & Grum, 2003).

*System Redesign*

The collaborative and landmark study of the Robert Wood Foundation and use of

the Chronic Care Model led to improved interactions between informed, activated

patients and a prepared proactive team to support self-management and behavior change

(Moore, 2006; Wagner, 1998).

*Figure 1. The Chronic Care Model (Wagner, 1998) used with permission*

**The Chronic Care Model**

Community
Resources and Policies

Health Systems
Organization of Health Care

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

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As shown in *Figure 1: The Chronic Care Model*, system redesign clustered in six

areas: health care organization, community resources, self-management support, delivery

system design, decision support, and clinical information systems. This was the synthesis

of best evidence but it did not provide a step-by-step formula. It was flexible so as to

accommodate new emerging evidence. The author believed when patients present with

acute problems, practices need to go beyond the chief complaint and include preventive

care and chronic conditions. Encounters for chronic care were still treated as unique

events rather than a continual process. Pulling up an electronic medical record helped

expose gaps and care opportunities (Bodenheimer, Wagner, & Grumback, 2002).

To achieve the Six Aims of the IOM (Wagner, et al., 2001) along with system

delivery redesign, additional skills were required of health professionals. To accomplish

the shift from acute to chronic care and working within tight budget restraints, there was

a need to continually manage an expanding evidence-base use of technological

innovations. More clinical practice occurred within teams and delivery arrangements

changed patient-clinician relationships. According to Solberg, Klevan, and Asche,

(2007), new or enhanced skills include:

1. Use of a variety of approaches to deliver care. Include a provision that does not
   include face-to-face visits.

2. Communicate evidence-base with patients.

3. Communicate with patients to encourage shared decision making and self-
   management.

4. Identify errors and implement patient safety principles.

5. Have a patient-centered approach so as to not lose sight of the person who has the
   illness.

6. Continually measure quality of care and implement best practices.

7. Work collaboratively and with shared responsibility.

In the Solberg established practice, the use of Plan-Do-Study-Act (PDSA) cycles

used small tests of change before systematic changes involving extensive redesign. One

physician made changes of becoming more systematic, proactive, and used a team

approach which resulted in a sevenfold improvement in the care of diabetic patients while

the larger physician group had a threefold improvement.

*Workforce Issues and Preparation*

To better prepare health care professionals, there is a need to look at current

curricula and include teaching skills to support self-management and patient

empowerment. Covering content which has patient communications, information

systems, and research methods may change the direction because the emphasis is moving

away from patient adherence to patients who are key decision makers and full partners in

their care. As mentioned before, the Patterson (2001) study showed practitioners believed

they were empowering patients but by discounting patient experiential knowledge,

maintained an adherence style instead of partnering with patients to set treatment goals.

Didactic patient education was not as effective as information customized to

patients (Clark & Gong, 2000). The healthcare team needed to be competent in setting

goals, identifying barriers, and solving problems to overcome barriers while action plans

were established. Confidence levels of patients and health literacy needed be addressed to

have empowered patients actively involved in their self-management (Holman & Lorig,

2003).

Clinical information systems needed to be standardized, have organized

approaches to collecting, summarizing, and reviewing individual and aggregate data. A

disease registry that included information, results, and alerts for care opportunities

assisted in preplanned delivery of care and follow-up. Delivery system design utilized

health care teams to their highest level of functioning. By this, physicians were not

inputting data into a disease registry because it was more efficient to have other team members performing the function. Developing flexible, multi-skilled, cross-trained staff enhanced the performance of the team. Support personnel were trained in behavior change theory and self-management support as well as close follow-up and treatment adjustment. With acceptance of clinical guidelines and standardized protocols, work flow was more efficient. A lack of cross training of team members was a barrier to efficient care (Wagner, 2000).

The Iowa Legislative Commission on Affordable Health Care Plans for Small Businesses and Families (2008) included a section on the health care workforce and stated "having healthcare coverage alone does not ensure access to health care services, access requires a sufficient number of appropriate health care professionals" (p. 31). Iowa's situation was more acute because of an aging and rural population:

> The health care workforce of the future should focus more on wellness and prevention i.e., health care not sick care system and should maximize best practices and efficiencies in the delivery of services. To achieve this, our medical education institutions must adjust their curricula to be more proactive in teaching preventative health. (p. 32)

Qualitative and quantitative studies on implementation of the Chronic Care Model vary whether they had positive, negative, or no impact on processes that improved patient outcomes. Since the incorporation of POHCs at the Midwest Primary Care Clinics, quantitative studies have demonstrated several significant improvements in patient outcomes. Physician Office Health Coaches impacted outcomes by:

1. Standardized process of diabetes office checklist ensured evidence-based care.

2. Summaries from the disease registry were attached to the patient chart and chart reviews done to catch missed care opportunities.

3. Health coaches followed-up with patients about goals and adherence to medication (Mercy Clinics, n.d.).

The qualitative phenomenological study of Grange (2007) explored the style of leadership in interdisciplinary collaborative teams. Three behavioral health teams consisted of 26 participants from New York City Centers and each had semi-structured interviews to describe leadership styles within a team environment. It was clear no one profession addressed the range of resources needed to deliver healthcare services. There were barriers to developing teamwork due to variability in organizations, different levels of personal commitment to the group process, role confusion, and unfamiliar terminology and technologies. Each discipline had its own culture, goals, and values but effective collaborative strategies could have been used in the delivery of care to chronically ill patients.

<div align="center">Theoretical Context</div>

Most theories related to helping patients with chronic illness had roots in social cognitive theory and behavior change theory. Self-efficacy focused on whether individuals believed they had the capability to produce outcomes (Bandura, 1996). Bandura emphasized beliefs were more potent than objective circumstances because they provided the motivation to act and influence how much effort was put into a behavior. It was assumed that high self-efficacy should lead individuals to engage in behaviors that positively affected their health. The social cognitive theory proposed people learn by modeling.

The Transtheoretical Model (Prochaska & DiClemente, & Norcross, 1992) was a model of intentional change. It involved emotions, cognitions, and behavior with a reliance on self-report. The progress of change moved through a series of five stages:

1. Precontemplation-people have no intention to change and are unaware of a need to address a problem.

2. Contemplation- people were intending to change in the next six months and were more aware of the pros.

3. Preparation- people were tending to take action in the immediate future. They had a plan of action.

4. Action- people made overt modifications in their lifestyle within the past six months. Action was only one of the stages and not all modifications counted as action.

5. Maintenance- people were working to prevent relapse and were more confident they could continue the change. The model is illustrated in *Figure 2: The Transtheorectical Model.*

*Figure 2. Transtheorectical Model*



Stages of change model
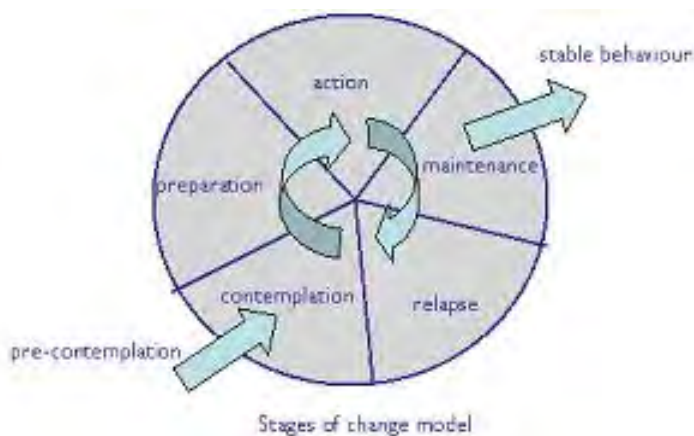
The model was applied to a wide variety of problem behaviors that included smoking cessation, exercise, low fat diet, medicine adherence, weight control and stress management (Velicer, Prochaska, Fava, Norman, & Redding, 1998). The model made no assumption about how ready individuals were to change which increased participation rates. It also recognized ebb and flow cycles of relapse and with proper support relapses became shorter. Prochaska et al. (1992) saw change not as linear but spiral. *Figure 3: Spiral of Change* illustrates spiral nature of moving from precontemplation, contemplation, preparation, action, and maintenance.

*Figure 3. Spiral of Change from Prochaska, DiClemente & Norcross, 1992, p1104*
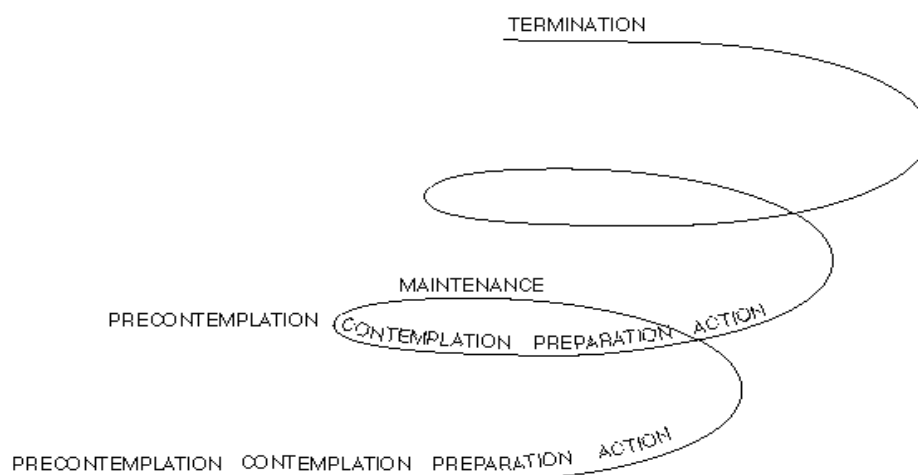


The doctoral dissertation of Reid (2005) studied the manner in which healthcare providers interacted as they coached, taught, and guided patients. This important role contributed to positive health management and outcomes. Effective healthcare coaches exhibited core attributes of clinical, technical, and interpersonal competency which was more than the delivery of content. Reid commented coaching occurred in situations when patients faced some kind of transition. Effective interpersonal interactions occurred

through listening, supporting, encouraging, validating, and counseling. Outcomes of coaching were measurable in the case management study of diabetics who were followed for six months as they participated in a program of weight loss and metabolic control. At the six month follow up, participants completed their perception of the case manager as coach using a perceived coaching scale. The results (n=88) showed perceived coaching was mildly correlated with improved moderate and vigorous activity of the participants but not with weight loss. Regression analysis revealed perceived coaching to be a significant predictor of metabolic control. This study added the perception of coaching to the already known value of content, frequency, duration, and longevity of contact a person had with the health coach to successful achievement of behavior change and desired health outcomes.

Health care delivery that incorporated motivational interviewing coached patients in a new way. Motivational interviewing was a client centered directive counseling method that enhanced intrinsic motivation for change by exploring and resolving ambivalence (Miller & Rollnick, 2002). It was first described by Miller in 1983 and offered a practical, common sense approach for supporting clients/patients in making and sustaining healthy behavior change. It drew on existing models of counseling and behavior change theory. This interpersonal style of acceptance, empathy, collaboration and reflective listening elicited patient strengths, reasons for change, and a way to achieve the change. In expressing empathy, coaches sought to understand from patients' points of view. To develop a discrepancy, the guided conversation voiced where they were compared to where they wanted to be and it was the patients who voiced the need for change. The use of open-ended questions drew out facts and accessed readiness for

change. With the use of encouraging statements, change readiness set the goals. The use

of a readiness ruler measured confidence levels of patients and could describe barriers or

hesitation to move on. The communication style balanced three hats (a) follow by taking

in and observing, (b) guide by support, encourage, and awaken, and (c) direct by steering,

leading, and sometimes telling for the coach was the expert in the situation. The

fundamental approach to motivational interviewing was a partnership that honored

patients' experience and perspectives, and realization that change resided with the

patients. Goals were drawn from patients' perspectives, and acceptance of their right and

capacity for autonomy (Miller & Rollnick, 2002). An example of the conversation flow

guide is Appendix D.

To implement the health behavior change process, outcome and behavior goals

were differentiated and applied. Outcome goals were the big vision not easily measured

but behavior goals were visible and were the steps to reach the outcome. Behavior goals

were written and set up as SMART goals (Nikitina, 2008), SMART being an acronym for

Specific, Measurable, Attainable, Realistic goals with a Target date for completion. For

example for the next two months, the patient states he or she will walk on Monday,

Wednesday and Friday at 3:30pm for one hour with Jenny in the park near his or her

home.

The Chronic Care Model has been a type of evidence-based guideline that assisted

chronically ill patients in making behavioral changes. The implementation and feasibility

was the area that needed research and assessing the long-term effects of its diffusion

throughout the system continued to need study. All efforts would develop a better

understanding of what it takes to truly care for the chronically ill in our communities. The

IOM report described a "continuous healing relationship" (Institute of Medicine, 2001

p.70) which looked beyond our traditional delivery of health care to include more cost

effective interactions and follow-up. Physician Office Health Coaches identified chronic

care delivery opportunities by creating and maintaining a disease registry which in turn

nurtured a relationship with patients. They utilized the techniques of motivational

interviewing to assist patients in goal setting and tracked patient progress through chart

reviews. The POHCs also challenged old ways of delivery to try new processes using

PDSA cycles. A sample worksheet is Appendix C. These new delivery methods produced

results (Mercy Clinics, n.d.).

In summary, the literature reviewed states the need for a healthcare system

redesign incorporating the IOM's ten rules of redesign. Creation of a medical home for

patients which is directed toward the care of the whole person enhances access,

coordinating care, and self management support. The theoretical context of the

Transtheoretical Model can be used to achieve intentional change of patients and health

care providers to redesign the current health care system. The role of POHC in the design

is crucial to achieving this goal.

CHAPTER III: METHODOLOGY

Research Design

This phenomenological qualitative study followed the structure of Moustakas (1992). The researcher attempted to approach the lived experience with a sense of freshness to elicit new and enriched data. Polit, Beck, and Hungler (2001) define research design as "the researcher's overall plan for answering the research questions or testing research hypotheses" (p167). Data collection with multiple forms of data and adequate time spent in the field framed the study and utilized the unique characteristics of qualitative studies.

The broad steps within transcendental phenomenology are: epoche, phenomenological reduction, imaginative variation and finally the synthesis of texture and structure (Moustakas, 1992). The following are the broad phases:

1.  Epoche- Suspension of all previously held preconceptions, biases, theories, beliefs or habitual modes of thinking in order to effectively explore consciousness. Moustakas called this bracketing. "Looking, watching and becoming aware without importing our prejudgment of what we think, imagine or feel" (p. 37).

2.  Data collection- Every effort was made during the interview to create a relaxed and informal atmosphere in order to facilitate relating experiences. Data collection included the use of open-ended questions and comments guided by the research question.

3.  Phenomenological reduction- Description of the phenomenon given in textural language. After a sense of wholeness was achieved, the eidetic reduction was undertaken which was the identification of essences. This was the essence or form

of shared experience. It was the search for commonalities. Horizonalization considered every statement made during the interview as having equal value. Naturally occurring meaningful units then emerged and were clustered into themes.

4. Individual textural and structural descriptions- When all horizons had been clustered into themes and reflected upon, an individual textural description for each of the participants was constructed giving verbatim examples from transcribed interviews.

5. Composite textural and structural descriptions- From the individual textural descriptions, a composite textural description was developed and depicted the experiences of the group as a whole.

6. The synthesis of texture and structure-The last phase was to synthesize and integrate insights contained in the transformed horizons into a description of the structure of the phenomenon. Essences of an experience were never completely exhausted and this represented essences at a particular time and place as seen through the vantage point of the individual researcher following an intuitive and reflective study of the phenomenon (Creswell, 2007; Moustakas, 1992).

In phenomenological research, the researcher also has a personal interest in the research question. The researcher, like patients, seeks healthcare which is coordinated and timely. Adapting healthy behaviors are difficult alone but with POHC support it seems possible. The researcher has felt underserved by the current health care delivery system and seeks to objectively review the experiences of POHC as they seek to deliver care according to the Chronic Care Model. As the researcher became immersed in the

study the researcher became somewhat a participant and therefore used reflexivity and

the process of bracketing to reflect on personal preconceived values, biases, assumptions,

and took a self-critical stance to the study. Polit et al. (2001) stated:

> Bracketing refers to the process of identify and holding abeyance preconceived beliefs and opinions about the phenomenon under study. The researcher brackets out the world and any presuppositions in order to confront the data in pure form. Intuiting occurs when the researcher remains open to the meanings attributed to the phenomenon by those who have experienced it. (p. 215)

At the beginning of the study the researcher began a journal and wrote down

feelings, preconceptions, conflicts, and assumptions held about the study. The

researcher's personal opinions of encounters with a clinic were suspended and set aside

while interviewing participants and analyzing findings. This enabled self-monitoring to

limit bias and increase objectivity. Multiple methods of collection of data and

interpretation or triangulation were used to more accurately represent the reality of the

study (Polit et al., 2001). By using interviews, field notes, observation of group meetings,

and reviewing support documents about the POHC experiences, the data converged to

accurately present the phenomenon. Lincoln and Guba (1985) recommended increasing

creditability by prolonged engagement or sufficient time in data collection so as to have

an in-depth understanding of the culture, language and views of the group. As Lincoln

and Guba noted, "If prolonged engagement provides scope, persistent observation

provides depth" (p. 304). This study spent almost a year in the field, included interviews

with 50% of the POHCs and observation of group meetings which ran at least two hours

and were attended by most POHCs on February 21, March 13, March 27, April 3 and

April 17, 2008.

Identification of Sample

A purposeful sample of seven POHCs was selected by the clinic administration

Director of Quality Improvement. The director was responsible for the implementation of

quality improvement initiatives and started the POHC program. At the time of the study,

a total of fifteen POHCs were employed at family practice or internal medicine clinics.

All participants were employees of a Midwestern clinic system and had been in the

position of health coach for at least one year. Methodological rigor was attained through

verification, validation, and validity (Morse, 2001). Verification by literature review,

interviewing until saturation, extensive field notes, and observation of group meetings

was done. Individual semistructured interviews were done because they tend to evoke

personal experiences and perspectives. The semistructured questions were designed by

the researcher to incorporate all the aspects of what POHCs did at the clinics. Group

meetings attended by all 15 POHCs were held twice a month in which training and

sharing of learning occurred. Observations of group meetings were useful to capture

interpersonal dynamics and culture and were added to interview themes. Notes in the

field from interviews and group meetings, collection of handouts and materials, and

reflective descriptive notes all added to record the social phenomena. Validation was

done by multiple methods of data collection, data analysis and coding using NVivo,

member-checks by the participants, review of documents, and an audit trail.

Ethical Considerations

Permission for entry into the field and use of participants was obtained after

reviewing a presentation at an evidence-based conference made by the Quality

Improvement Committee of Mercy Clinics Incorporated. The director of the committee

was briefed on the research proposal and suggested POHCs to interview. The director made first contact with participants and the researcher followed up with an e-mail asking for convenient appointment times for interviews lasting no more than one hour. This lessened the potential of disruption of clinical workflow. At the time of the interview, participants gave informed consent. The researcher did not personally know the POHCs so there was little power imbalance, vulnerability, or risk to participants.

In 1974, the National Research Act was passed by Congress and the National Commission on Protection of Human Subjects was created. This act directed all institutions that sponsored research to establish Institutional Research Boards (IRB) or committees to carefully review any proposed research involving human subjects (Berg, 1995). To fulfill the requirement of the IRB from College of Saint Mary, the researcher completed the web-based training course "Protecting Human Research Participants" accessed from the National Institute of Health website http://phrp.nihtraining.com/users/login.php (Appendix L). The researcher submitted documentation on how informed consent would be obtained and prepared the document "College of Saint Mary Rights of Research Participants" (Appendix G). After being reviewed by the IRB, the study was granted approval # CSM 08-13 for one calendar year until April 25, 2009. Approval was also requested from the Institutional Research Committee at Mercy Medical Center, Des Moines, Iowa. After an application for waiver of consent (Appendix H), a receipt of the application (Appendix I) was sent and the committee reviewed the research proposal at the April 18, 2008 meeting. Approval was granted a Waiver of Consent April 9, 2008 as MMC2008-006 (Appendix K). Findings of the study will be made to the committee in a final report.

Giving back to the group of health coaches was done as the researcher reported findings at one of the twice a month support meetings. The POHCs gained from the study as support systems were reviewed, strengthened and the essence of their experiences expressed. This not only helped current POHCs but also future coaches.

Procedure

After approval from the College of Saint Mary's Institution Research Board # CSM-08-13 and the Mercy Medical Center Institutional Research Committee Approval # MMC2008-006 for waiver of consent, semistructured interviews were conducted over 12 months at clinics where POHCs were employed. All interviews were scheduled by phone or e-mail and at that time an explanation on the nature of the research and procedures was given to participants. At the time of the interview, informed consent was obtained and the participants understood they could withdraw from the study at anytime. The semistructured interviewing format with core questions and probing questions (Appendix M) was used to increase reliability across the different interviews. All interviews were tape-recorded and transcribed verbatim by a third party and checked for accuracy by the researcher. Participants were available for repeat interviews. Interviews lasted an average of 60 minutes and the researcher took notes during the interviews as well as adding field notes within 24 hours. Interviews were usually held at a location within the clinic selected by the POHC. This made the atmosphere nonthreatening, and nurtured open discussion. The sites varied from a private office which two coaches had and usually consisted of a desk, computer, telephone, and book shelves containing patient teaching materials, community resources, and drug company handouts. Two POHCs shared spaces with other clinic employees and the office set-up was a larger room with a personal desk,

computer, phone, and shared space for teaching materials as well as storage for patient x-rays and overflow of clinic supplies. Two coaches from the same clinic shared an office; each had a desk, computer, phone, and a large round table to sit with patients while conducting patient education. The room was filled with diagrams, charts, and examples of food choices for healthy eating. One coach only had counter space in a common area and so the interview was moved to a vacant physician office. Without a private office, the POHCs interacted with patients in examination rooms.

The researcher assigned a letter to each POHC interviewed and the letter was used to identify audiotapes. No other person had access to the chart listing names and corresponding letters. At no time did the coach's name appear on the audiotape or transcript which upheld privacy. After original transcripts were compared to audiotapes and areas of ambiguity were identified, the researcher returned the transcripts to the participants to member check validity and accuracy of content. After validation of transcripts, the audiotapes were erased. The transcripts of interviews were maintained in a locked file cabinet in the private locked office of the researcher.

To obtain further richness of the data, the researcher observed twice a month support meetings of the POHCs held by the quality improvement committee at the clinic administration office. Each meeting had a prepared agenda sent out in advance by e-mail and covered topics of health literacy, medication adherence, shared medical visits, health behavior change, PDSA cycles, use of a disease registry database, and involvement in quality improvement activities. The researcher remained uninvolved in the social interactions observed but could ask for clarification of terms or comments. At the fall 2007 meetings, a great deal of time was spent on updating the disease registry and pay for

performance values. In spring 2008, more time was given to teaching motivational

interviewing, interacting with patients, and sharing problems about difficult patients as

well as successes with other patients. Notes were taken during the meetings and

observations were recorded as field notes the following morning. These in depth and

regular interactions added extensive rich and robust descriptions of the observed events.

Data Analysis

This qualitative study used phenomenological methods for interpretation of the

data. The researcher used reflexivity and bracketing to lay aside preconceptions regarding

the phenomenon under investigation. Some data analysis occurred simultaneously with

data collection. In that way saturation was achieved when no new data emerged.

Analyzed transcripts allowed extraction of significant phrases and sentences were

clustered into themes. Using the steps of Moustakas (1992) and simplified by Creswell

(2007), the phases followed were:

1. Epoche-The researcher journaled personal experiences with the phenomenon so
   as to set aside bias and more focus on the participants in the study.

2. Data were collected and transcribed. Transcripts were member-checked for
   accuracy.

3. A list of significant statements was developed which were treated with
   horizonalization or equal worth. NVivo software (Qualitative Software
   International, 2008) was used to organize coding by marking significant
   statements and collecting into themes as tree nodes. Transcript dialog was
   organized as child nodes within the tree node hierarchy and memos of

observations were linked to corresponding tree nodes which were meaningful units.

4. Textural descriptions were what the participants experienced with the phenomenon and were described by verbatim examples of dialog from the interviews. The structural description of the setting and context in which the phenomenon was experienced was described in the procedure section which detailed the clinic settings in which the POHCs work.

5. The composite descriptions were expressed in the results section and expressed in tables and figures.

6. The final step was to "write a composite description of the phenomenon incorporating both the textural and structural description. This passage is the essence of the experience and represents the culminating aspect of a phenomenological study" (Creswell, 2007, p. 159).

Results were integrated into an in-depth, exhaustive description of the phenomenon. The researcher's own laptop computer was used for analysis and it was solely used for this research so as not to be available to others which further secured privacy of participants.

CHAPTER IV: RESULTS

Introduction

To address the gap in delivery of chronic care, a Midwestern clinic system created a Physician Office Health Coach position and POHCs had many roles while implementing the Chronic Care Model. By in-depth interviews with seven health coaches, the researcher sought to describe how the POHCs saw their role, and their interaction with providers and patients. The content analysis assessed written documents, observations, and field notes from group meetings to organize what the researcher had seen, heard, and read.

Utilizing NVivo software (Qualitative Software Research International, 2008) verbatim transcripts from POHC interviews were visually coded (Richards, 1999). The researcher also attended twice a month POHC support meetings and field notes were added as memo links. Attributes of the interviewees are listed in *Table 1. Attributes of Physician Office Health Coaches.*

*Table 1.  Attributes of Physician Office Health Coaches*

|  | Number of nodes | Years as healthcare worker | Fulltime or part time | licensure-certification | Years as POHC |
|---|---|---|---|---|---|
| Interview A | 21 | 10 | Full Time | CMA | 1 |
| Interview B | 30 | 18 | Full Time | RN | 3 |
| Interview C | 14 | 11 | Full Time | RN | 2 |
| Interview D | 19 | 4 | Part Time | RN | 3 |
| Interview E | 18 | 22 | Full Time | RN | 2 |
| Interview F | 22 | 22 | Full Time | RN | 2 |
| Interview G | 28 | 20 | Part Time | LVN | 2 |

Most of the POHCs worked full-time although two of the seven currently work part-time. Licensure or certification was primarily as registered nurses except for two of the coaches who were a Licensed Vocational Nurse (LVN) and a Certified Medical

Assistant (CMA). The coaches had been in the role as a POHC for one to three years and

their healthcare experience ranged from four to twenty-two years.

Qualitative analysis offered insights into the social, emotional, and experiential

phenomena of the healthcare role of these health coaches. From the investigational

interviews, nine themes emerged and are illustrated in *Figure* 4: *Physician Health*

*Coaches Interview Themes.* The nine themes are represented in the model and different

shapes represent a new different theme.

*Figure 4. Physician Office Health Coaches Interview Themes*
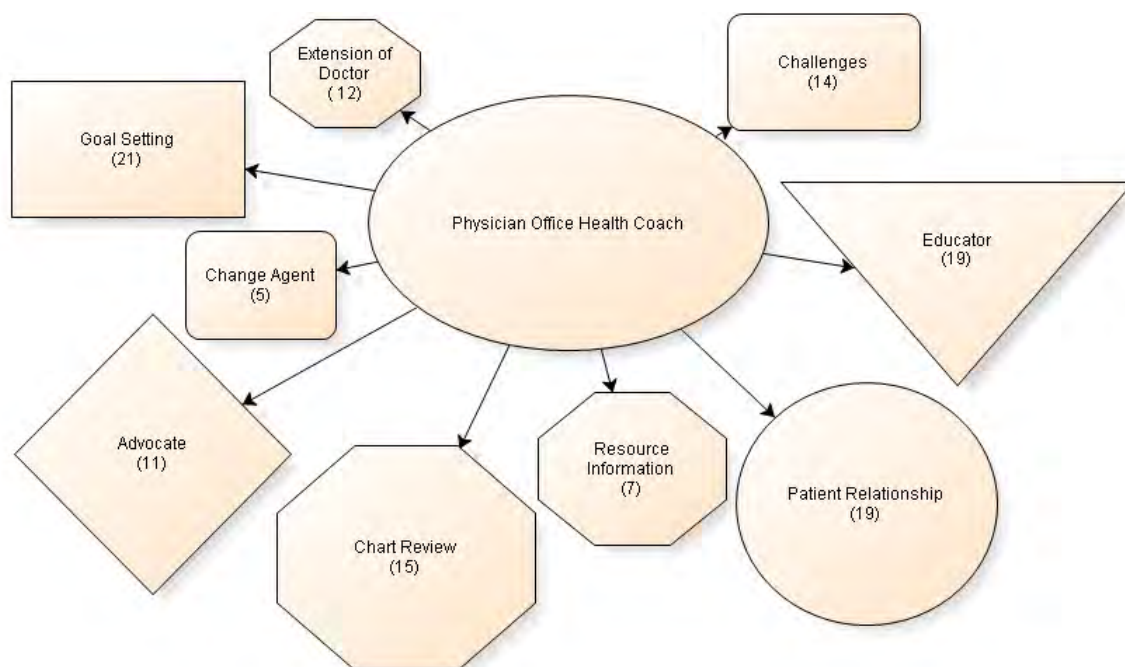


The POHCs believed they were there to motivate patients and set goals. They

equally saw themselves as educators and working on developing relationships with

patients. Coaches spent time reviewing charts, being advocates for patients, being an

extension of the doctor, being a source of information, and as a change agent within their

clinic. The POHCs also described several challenges. The connections between the

various roles were very rewarding and challenges emerged when connections broke down.

<div align="center">Data Analysis</div>

Visual coding was done by reading and rereading transcripts, identifying data passages that belonged to categories and creating tree nodes as well as sibling or child nodes. The process lead to a discovery of significant themes coded as tree nodes, which provided rich descriptions of each unique theme. Each theme was described and illustrated with quotes in the following sections. *Table 2: Tree Nodes as Themes from POHC Interviews* show the number of nodes coded as themes for each interviewee and whether memo links or field notes were linked to the nodes. All themes were referenced in the interviews of more than half of the POHCs and the number of significant passages for each theme ranged from 21 down to five.

<div align="center">*Table 2. Tree Nodes as Themes from POHC Interviews*</div>

| Type | Name | Memo Link | Sources | References |
|------|------|-----------|---------|------------|
| Tree Node | Goal setting-motivating- Orange | Yes | 7 | 21 |
| Tree Node | Educator- Red | | 6 | 19 |
| Tree Node | Relationship with patient- Navy blue | Yes | 7 | 19 |
| Tree Node | Chart review- Purple | Yes | 6 | 15 |
| Tree Node | Challenges- Green | | 6 | 14 |
| Tree Node | Extension of doctor- Light blue | Yes | 6 | 12 |
| Tree Node | Advocate- Maroon | | 5 | 11 |
| Tree Node | Resources Information- Pink | | 5 | 7 |
| Tree Node | Change agent | Yes | 4 | 5 |

*Theme 1: Motivating and Goal Setting*

The theme with the most number of significant interview passages (21) was setting goals with patients. The POHCs were supported by their physicians and educated in motivational interviewing through their support meetings. They felt well equipped to assist patients in setting clear, concise, realistic, measurable goals which helped patients learn self-management techniques. Coaches used the education aids, the 5A's worksheet (Appendix B) and Conversation flow (Appendix D), to guide them. The 5A's worksheet broke down self-management support into:

1. Agree to an agenda. Write down what the patient's goal is.

2. Assess readiness to change, how important this is to them, and their confidence of success.

3. Advise by asking what the patient would like to talk about or what information they would like. Information is not given out if the patient does not ask for it. There is an exchange of elicit- provide-elicit until the patient has the information they need to set their goal.

4. Assist the patient to develop a personal action plan. Identify any resistance or barriers and emphasize this is the patient's goal that they feel ready to work on.

5. Arrange contact with the patient and they have a plan of action to start on. Usually the POHC called in a few days to find out how well it was going. If needed they adjusted the plan, or reinforced the advances made.

*Figure 5: Percent Interview Coverage- Goal Setting* represented the percent of each POHC's interview related to goal setting with patients. All seven coaches made comments about motivating patients and using techniques discussed at support meetings.

*Figure 5. Percent Interview Coverage- Motivating and Goal Setting*
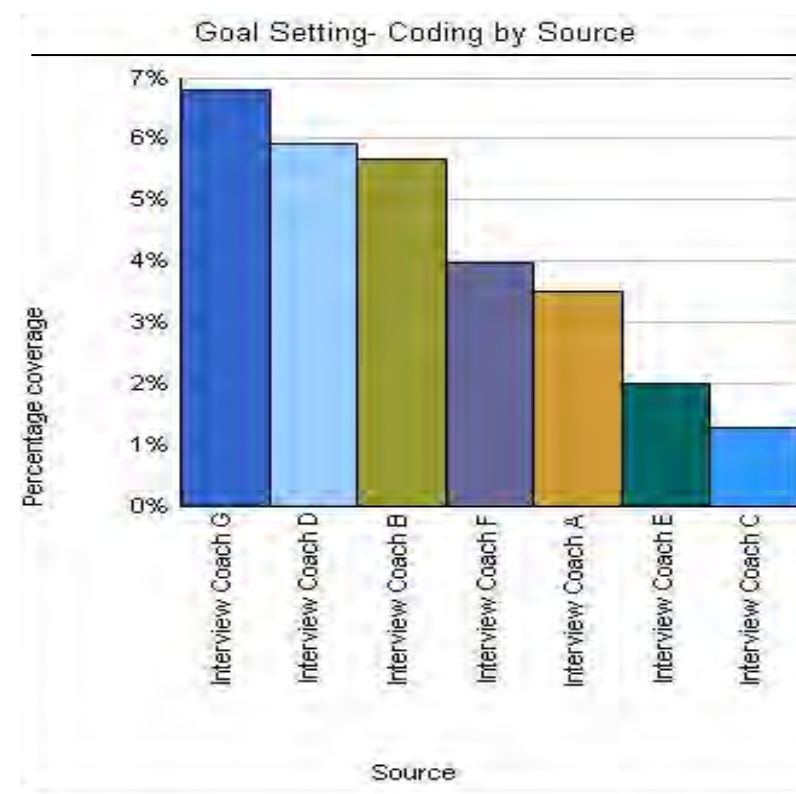


From *Figure 5: Percent Interview Coverage- Goal Setting*; the percent of dialog ranged

from  six and eight tenths down to one and three tenths percent. Coach G had the largest

percent and shared:

> We usually try to start out just by setting short-term goals and not making big changes. I always tell them 'don't go home from here,' if I'm doing a hypertensive education, 'don't go home and empty out all of your cupboards and refrigerator and then you have to start a new life.' That's not what this is all about. If I'm teaching them on nutritious eating –chances are they're probably doing a pretty good job – we just need to tweak it. We'll just keep a log for a week or so and then we'll look at that log and see what's going on with them. Give me a call or I'll call, however we set it up to do and then we'll kind of review. We don't have to make humongous changes all at once. Small steps. Set our goal but set the small steps to reach that goal.

She also said:

> One lady I helped her, I think she lost 15 pounds over a few months time and we really worked hard and we got those numbers down for her weight and I

talked to the doctor in the meantime and we gave her a change in her medication and she came in one day and her blood pressure was like 130 over 70 and she was just beaming. This is what makes it worthwhile when we see those kinds of outcomes.

Coach B with six percent coding coverage talking about goal setting said:

If I can only affect one person a month, at least its one person I'm affecting. I don't shoot for big numbers but I really think that once the word gets out, that hey, this person is here and they're there for them, then I think it can affect people's lives. Not affect their lives but more their lifestyle changes and make them more aware that they do need to do something.

And later:

They have to understand it is something you have to do every day. Until people realize that, sometimes it takes them a couple years usually until something happens and then they say, 'ok I've got to really do something now.' Or until they see their numbers really going up and they thought they had it in control. But until they get to that point you really can't do anything. You can – you keep talking to them. It's got to be them and I think that's the big thing that I want to work on is really empowering the patient – that they want to be there – they want to have that control but that they control the disease instead of the disease controlling them.

From field notes at coaches' support meetings comments were: "by looking at the data in the disease registry, we can tell if there is a trend with a particular provider who needs to be educated about the need for the test." Another coach added "if the patient understands why they remember they need the microalbumin urine test, they remind the provider so it is not missed." Coach D realized in the last week that sometimes it was important to be empathetic and back off of the education. She had to switch off the educator and call on her skills of behavior change management. Many others agreed and commented they learned so much from the other coaches in the group.

*Theme 2: Educator*

The POHCs perceived their next important roles were equally as educators which had 19 references to interviews as did working on relationships with patients. The POHCs saw themselves as the healthcare professional who had the resources such as information from clinical guidelines, and the support of the physicians to take as much time as patients needed to be educated about their chronic disease.

POHCs had the task of educating newly diagnosed patients with diabetes about diet and the use of glucometers. They were able to take time with patients to be sure they understood and were comfortable with injecting insulin. If there were changes in medication, the POHC would teach patients the new schedule. In *Figure 6: Percent Interview Coverage- Educator*, six of the seven POHCs commented on being an educator and the percent dialog ranged from ten and six tenths to one and one tenth percent. Coach C related to being an educator and spending ten percent of her interview on this theme was the largest amount any coach talked about any one theme. The coach commented:

> Most of them want to do the right thing so they want to know their numbers and keep track of them. The patients live with their disease twenty four hours and they see the doctor three to four times a year for five or ten minutes so that is only thirty minutes. That isn't enough to do all the changes the doctor wants- lower the blood pressure, lose weight, exercise, get the blood sugars down and the A1cs in line.

*Figure 6. Percent Interview Coverage-Educator*
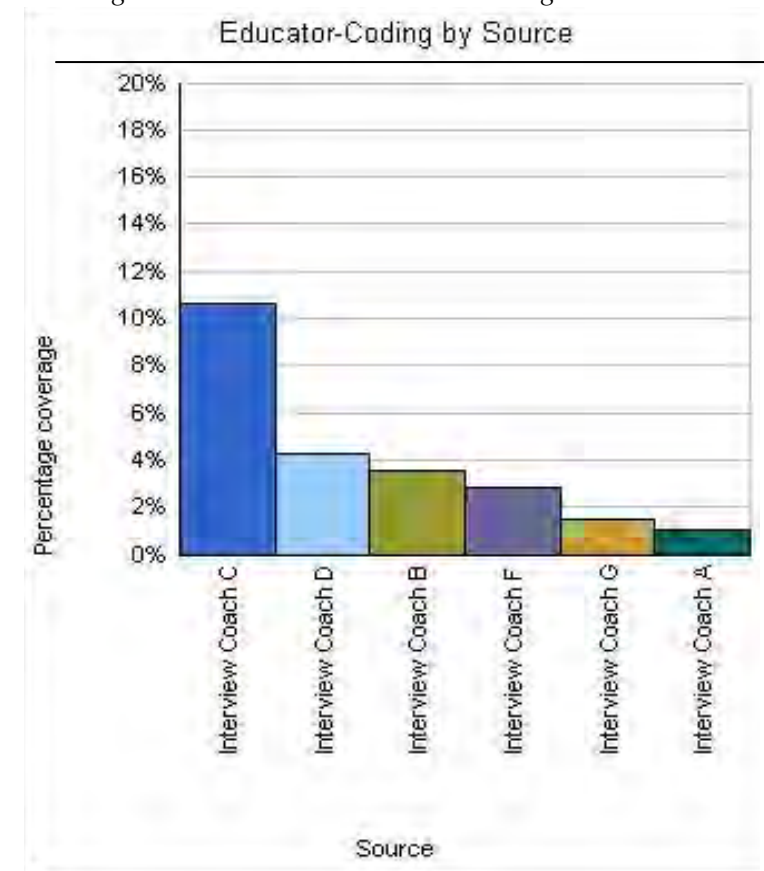


Coach B at three and one half percent dialog about being an educator said:

> I think that is what we have to do better- educate the patient. This is why you are going there. We'll still watch you. We'll get all the information and educate them about chronic diseases so that they are empowered to do more self-care and understand where the numbers need to be and give them more power with their health care.

Coach D with four and three tenths percent said, "So I love educating people and I love conveying knowledge or passing that on. I was really excited about the health coach position and the potential to help educate patients."

*Theme 3: Relationship with the Patient*

An equal amount of nodes were coded from interviews about the POHCs'

relationship with patients. The coaches felt it took time to build the relationship and at

first some patients might have been reluctant. Patients would sometimes refuse, not return

calls, or not have the time. Most coaches kept offering, calling, and continued to follow

up because they never knew which day would be the one when the patient was ready to

make the change and take the step from precontemplation to contemplation. Everyday

was a new opportunity to have an effect but first the patient needed to trust them. *Figure*

*7: Percent Interview Coverage- Relationship with Patient* had dialog from all seven

coaches and ranged in percent of interview from eight and two tenths to one half percent.

*Figure 7. Percent Interview Coverage Relationship with Patient*
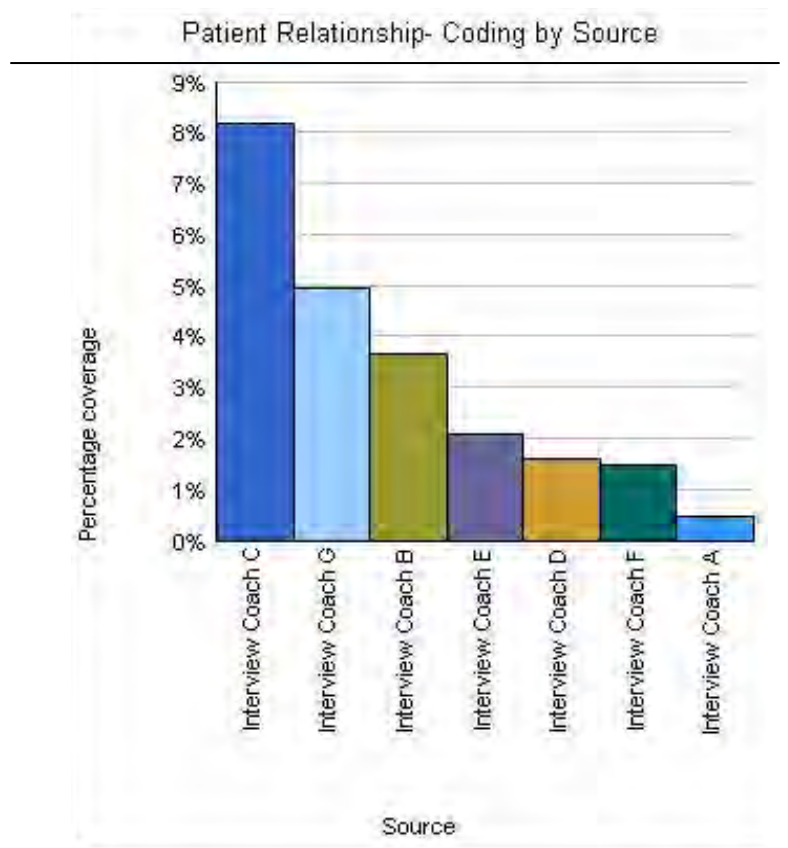
Of the seven POHCs, Coach C had the largest amount talking about relationships with patients and spoke about it by saying:

> Having the opportunity to take as much time as the patient needs to set goals. I discuss where they are at, what they think they can do or try, and get started. I can then later follow up with a phone call and see how they are doing. Sometimes they have  questions and I can answer them right away. I think it's the best job in the clinic because I feel I really have a relationship with my patients. We have about 600 patients on our disease registry and I feel I get to know them.

Coach G at five percent talked about patient relationships and said, "You have to give it time for that relationship. As that grows, also does the trust and being able to talk with the patient and set goals and working with them to achieve those goals." Through the interview she had comments of "doing one-on-one, developing that trust between you and the patient, giving them a lot of reassurance, and I think I have to establish a good rapport with that patient."

Coach B's interview covered three and seven tenths percent on patient relationships and said:

> With my diabetic people, I have them on my calendar and they're marked with their name because I always do a 2-week call and follow-up – 'How are you doing? Any problems? Are you struggling with any of the goals we set for you?' Everybody that I do diabetic education on is followed-up on in two weeks. Everybody that starts insulin gets follow-up in a week and they might be followed up weekly until their blood sugars are better or until I feel that they are comfortable with giving insulin –that they are ok with that. Those people are marked down on our calendars to make sure that I call them. We just started the hypertensive so we're kind of figuring which way is the best to go with that to get these people called back because it's a big population.

And:

> I always write little notes on when I do education, like what they do, if they're a truck driver, or if they have grandkids, grandmothers like to bake cookies, anything like that. The more personal you are with the patient, the better they feel. They open up better. You have them say, 'oh, you remembered.' Almost shocked! They don't know I wrote it down. I do think it's more personable.

From field notes taken at support meetings, the coaches mentioned trying to coach over the phone was more difficult because there was less nonverbal communication. They agreed it was important not to spend time on the negative things, but rather to move forward in a positive direction. Coach F mentioned it was important to ask if "we were catching them at a bad time and listen to the tone of their voice". Others mentioned they liked the phone conversations because all the eye contact distracted them from really listening intently to what their patient was saying. Coach G said "you really know you are connecting with the patient when they are doing all the talking".

*Theme 4: Chart Review*

The next tree node reference was Chart Review which is *Figure 8: Percent Interview Coverage- Chart Review* and had 15 references. Six of the seven POHCs made significant comments and the percent interview talking about chart review ranged from nine percent to nine tenths percent. Most POHCs had their own system that color coded patient's charts with the chronic disease or diseases the patient had and whether the patient was listed on the disease registry. Coaches would look at future appointments and when a patient on the disease registry was coming in, they would review the chart to see if patients were meeting clinical guidelines for the standard of care for their disease. They noted on the chart what opportunities existed to update lab tests, vaccinations, and preventative screenings. At some clinics the patient would have testing done at the beginning of the visit so lab values would be posted on the chart for the physician to see. The disease registry had a standard set up so testing or procedures that were past due were easily noted and POHCs made calls to schedule patients for needed updating.

Timely communication with patients helped develop relationships and the concept of a

medical home.

*Figure 8. Percent Interview Coverage- Chart Review*
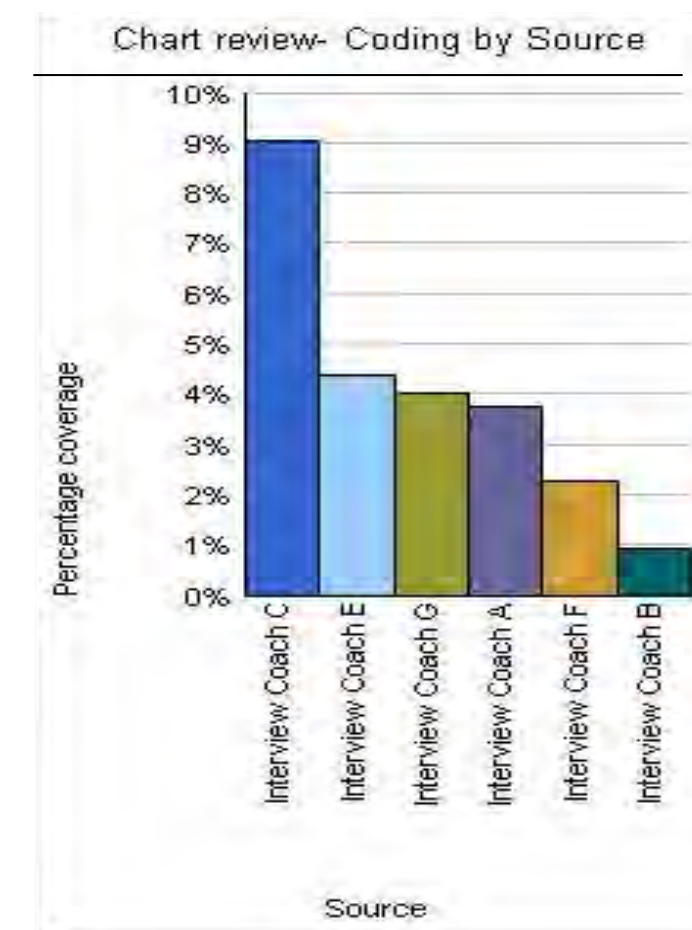


Coach E with four and four tenths percent of her interview spent talking about chart

review said:

> The role of the health coach is someone in the physician's office who can
> be in charge and complete pre-chart visit reviews of patients who are coming in to
> the clinic to be seen and in those reviews being able to recognize and make the
> necessary notations on the charts for the doctors of things that are not meeting
> goals according to standards, guidelines, and who just haven't been in for awhile
> or have things that need to be done and follow-through with as far as lab testing,
> immunizations, complete physicals, any type of care that needs to be done.

Coach C with four and three tenths percent talking about chart review said:

> We pull the charts and see what needs to be done. Then I call the patients and get them to come in fasting and get the results for the doctors before they come in. We can then adjust medications and they know what they need to do before they leave. It worked better than calling them back because they may have questions and they don't ask them. I then call them a few days latter and see if the medication change is working. Sometimes they need encouragement or they didn't get the meds or they don't like the change. I can talk to them and be sure they can do it. Otherwise it might wait for the next appointment and it is too long a wait.

Coach A with three and nine tenths percent talking about chart review said:

> These charts are ones that I am working on our list of people who need to come in. Like this one who hasn't come in, in over a year. I'm working on trying to call to make sure they are getting in for their appointments and some of them are just checking to see if they've had their eyes examined and stuff that maybe we forget, the  doctors forget, to make sure that the diabetics are getting their eyes examined to make sure they're not getting any diseases or not going blind.

The researcher first started attending the coach support meetings when the group was spending a large amount of time doing chart reviews and upgrading the disease registry because the deadline was approaching for pay-for-performance measures. The health coaches would review opportunities to have disease registry patients come in to update measures of blood pressure, dilated eye exams, urine microalbumin, cholesterol, and HDL levels. At a certain date the number of patients meeting goals would qualify providers and/or clinics for pay-for-performance incentives. The health coaches understood the need to spend time on this aspect of their job but did not really enjoy it as much as time spent with patients.

*Theme 5: Extension of Doctor*

The next tree node group for discussion was extension of the doctor with 12 references. *Figure 9: Percent Interview Coverage-Extension of Doctor*, six of the seven

coaches discussed this theme and spent five and three tenths to only one tenth percent of

their interview on it.

*Figure 9. Percent Interview Coverage-Extension of the Doctor*
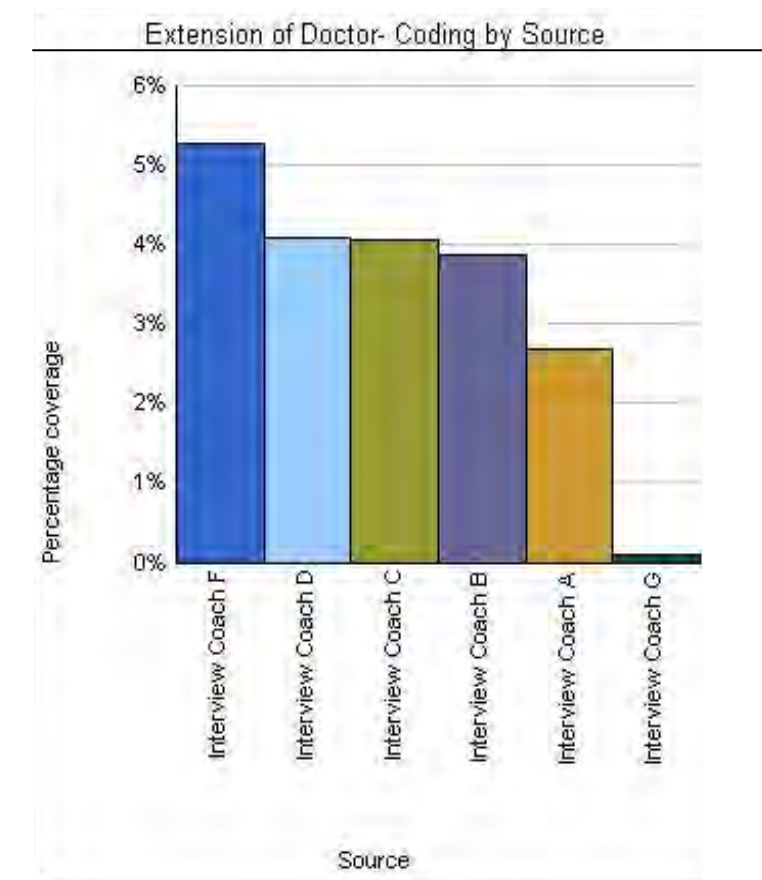


Coach F had five and three tenths percent of her dialog on extension of the doctor and

said:

> Not only are we middleman between the doctor and the patient but we're
> the middleman between administration and our doctors and there are times that I
> hear them talking about the future and I'm just sitting here thinking, ok, hmm.not
> sure if that's going to fly very well. When I took this job here I didn't work here
> as a clinic nurse so I was new to our docs. This has been a whole learning thing –
> I've got to learn how to work with them and do this job at the same time. It's not
> been the easiest thing but I'm kind of starting to understand them a little bit. The
> thing, too, that we have to remember, our docs want to make money and not all
> the time trying to help the patients is going to be a moneymaker. I'm a salary to
> them. Although in a roundabout way it all works out but you have to kind of

prove those kind of things, too because I'd love to have an extra person. I could sure use one.

Coach D had four and one tenth percent on extension of the doctor and commented:

> It's always hard to say what could have happened. I think there is definitely fewer patients that are having major events, like going to the hospital because of health coaching and because of making the doctors more aware that we really need the LDL lower than 100 or their blood pressure lower 130/80 – lower than not 135/85. We're getting tighter controls that way and I think that's helping. That might not be a direct relation of meeting with me but it's really me putting on those lab sheets blood pressure was 135/85 last time, recheck it if it's above 129/79 this time. And it draws the doctor's attention to it well, that's not good enough. I think it makes them look at things twice and maybe adjust medicines where they might have overlooked it.

Coach C also had four and one tenth percent on extension of the doctor and said:

> I am able to be there when the patient is ready. When the patient is ready to make a change. During the week, I call and touch base to see how it's going. 'Is it working out with your meds? How are the diet changes going? Have you had the chance to try those new exercises?' They can tell me and we can make adjustments. Or maybe they haven't filled the prescription and I can help them see the importance of it. I can reinforce what the doctor is trying to do.

Coach B had three and nine tenths percent of her interview talking about extension of the doctor and said:

> I think sometimes our doctors are busy and that they think they are doing a good job but they forgot about the last 15 that didn't come in because their schedule is already full so I think it's good to have us as a backup, watching those people that they don't fall through the cracks and having that in place so then we audit charts and we know this person hasn't been in for 6 months and we need to call them or send them a letter.

During coach support meetings it was shared that some coaches attended provider meetings and it helped with open communication about goals, clinical guidelines, and standards at their clinic. Coach D mentioned how much the clinic champion and clinic manager were engaged. Each clinic had a designated Clinic Champion who had the responsibility to organize and implement quality improvement projects. At the beginning,

Coach D just reviewed a few charts, and then she started doing goal setting using the

5A's form (Appendix B).

*Theme 6. Advocate for the Patient*

It can sometimes appear when the health coach was being an extension of the

doctor it seemed to work against the coach being an advocate for the patient. *Figure 10:*

*Percent Interview Coverage-Advocate for the Patient* as a coding source had comments

from five of the seven coaches and ranged in percent from seven and four tenths down to

three tenths.

*Figure 10. Percent Interview Coverage- Advocate for the Patient*
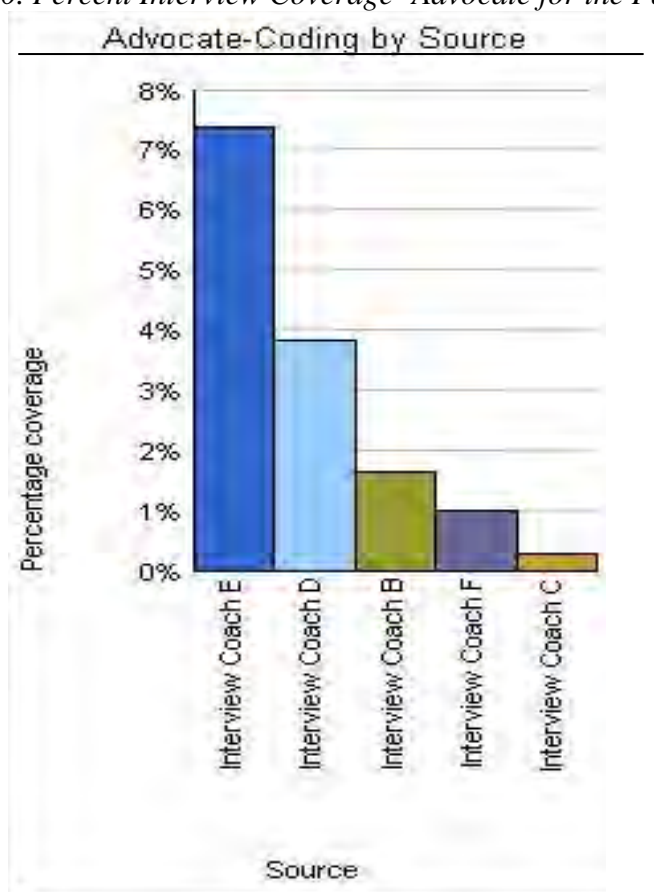
Coach E with the largest percent dialog on this theme said:

> We're kind of evolving here still but I see the change happening as I can call and follow-up with the chronic diseases after they leave and say 'you've seen the doctor, your blood pressure is still high, are you still taking the medicines, is there a problem with that?' Then you can work with them more. Maybe they didn't want to tell the doctor or didn't think to tell the doctor. 'I had a hard time getting my medicines down.' You can follow-up afterwards and maybe be able to make a change.

Coach D with three and eight tenths percent commented:

> I think we're a little slow to get them on it (insulin). People will come in undiagnosed diabetes; blood sugars high 200's-300's and they say 'oh you're still not bad here is the metformin. Try this' and really my perception is wow, let's be a little bit more aggressive in trying to bring these down right away and if they can back down off the insulin, that's great. You know, when I rule the world… I think they are a little more hesitant to get them started right away on insulin. I think there's a perception that patients are going to fight it and I don't know that it's a valid perception all of the time. I think if patients have the support and the education component and realize that you're there to help them with it and get through then they're more likely to do it. It's amazing how patients think it's going to be so painful and so scary to inject them with insulin until you do it with them once. And then they say 'really it's not as bad as I thought it would be.' Same with checking the blood sugars. It's not like when we were kids and they were checking our hemoglobin with those enormous needles.

Coach B had only one and seven tenths dialog about being an advocate but her comment was very powerful:

> I think imparting with the patient that I'm an advocate for them instead of an advocate for the doctor I think is a big thing to the patients to know that we're here for them. That's kind of our motto. When we started our thing was Patient Partners and Quality Care we have that on one of our shirts that we wear. 'We're not here for the doctor we're here for you. We're here to help you and be an advocate for you.' That's a big step to our patients.

*Theme 7: Resource Information*

*Figure 11: Percent Interview Coverage-Resource Information* covered a smaller amount of dialog as the health coaches were being interviewed but did cover time at the coach support meetings. Again five of the seven coaches commented on the types of

resource information they used while they were coaching patients and the percent of

dialog ranged from three and two tenths to one percent.

*Figure 11. Percent Interview Coverage- Resource Information*
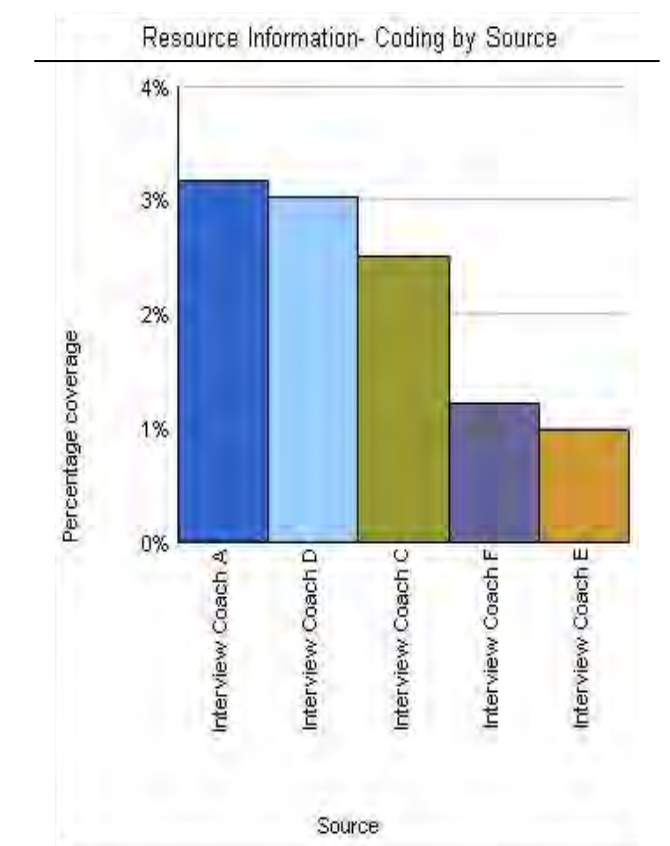


Coach D spoke three and eight tenths percent and said:

> …I get resource information from the Mercy Diabetes Institute. Many of the health coaches have taken the 4-day class intensive diabetic training course there and so that was a resource they showed us and we're able to order those through Mercy. Some of our other resources come from the drug reps and the doctors are very hesitant to hand out that type of stuff because a lot of it is branded. So I'll take a lot of that information and it collects dust so I really have a small rotation of things that I use and a large collection of things but only a few of them are getting used.

Coach C spent two and five tenths percent of her dialog on resources and mentioned:

> I like the material from the Diabetes Institute. I prefer not to use materials that have too much of the brand names on it. We don't want to push any product and we are supposed to use generics (it's an incentive for cost containment). The brand isn't important the facts are needed.

*Theme 8: Change Agent*

The health coach as a change agent is *Figure 12: Percent Interview Coverage-Change Agent.* Only four of the seven coaches spoke about this theme and it had five references. When one coach had an idea she had a place to discuss it and a tool using PDSA cycles (Appendix C). The PDSA Cycle Chart uses P̲lan, D̲o, S̲tudy, and A̲ct as a way to try small changes within the clinic.

*Figure 12. Percent Interview Coverage- Change Agent*
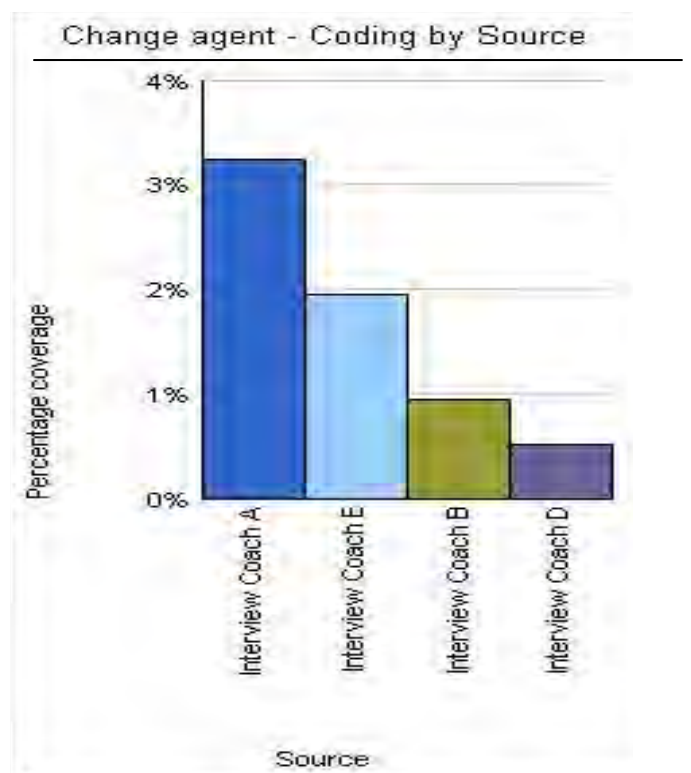
When the POHC had a goal, they would map out the small tests of change they wanted to try, plan how to do it with all the responsible parties, do the plan, get back together to study the measured results against the predicted results and either put the plan into action or step back and alter the original plan to try again. Two of the other coaches mentioned they believed some people seemed to think 'What now!' when they saw them coming at them with new ideas. Coach A with three and two tenths percent of her interview on this theme mentioned:

> Working as a CMA before this, before moving into this role, helped me know what the nurses can and cannot do when I'm asking them to get information for me. And how the doctors will react to me asking for certain information since you have those that sometimes resist wanting to do something- they want to be in charge and they don't want to be told what they have to do.

Coach E had two percent of her dialog on being a change agent and stated:

> I think it really helped starting out as a floater and then moving into the other stuff. I feel like I have a good rapport with each of the providers and I feel comfortable going to them. They kind of cringe when I come down the hallway.

Coach B only commented once about being a change agent and said:

> I think we do a lot of other things besides educating our patients. We do a lot in the clinic. We educate the staff. Watching the charts, making sure that the patients aren't falling through and the ones that are, at least touch base, are you seeing somebody else. And that's ok, but we need to know what's going on. I think having that contact with our patients, they feel, hey, they're doing something and they really care. And maybe if we care, they'll care.

At the coach support meetings different coaches mentioned the PDSA cycles they would like to try. Coach C wanted to recheck patient's blood pressures before they left to see if the pressures might go down. Coach E mentioned she noticed a need for more community resource information. She saw coaches that were a "one-man show" and needed the resources as a back-up. The resources needed to be assessed for high quality

and if they were effective. Another coach mentioned asking patients where they go for information and then individualizing the information. Coach E mentioned when they have a new idea for change they start with a meeting. She starts with how it is currently not working and says "let's work on a change and give it a chance".

*Theme 9: Challenges*

The last theme was about the perceived challenges of POHCs. Six of the seven coaches commented with 14 references in interviews and covered between six and one tenth to one and seven tenths percent of interviews.

*Figure 13. Percent Interview Coverage- Challenges*
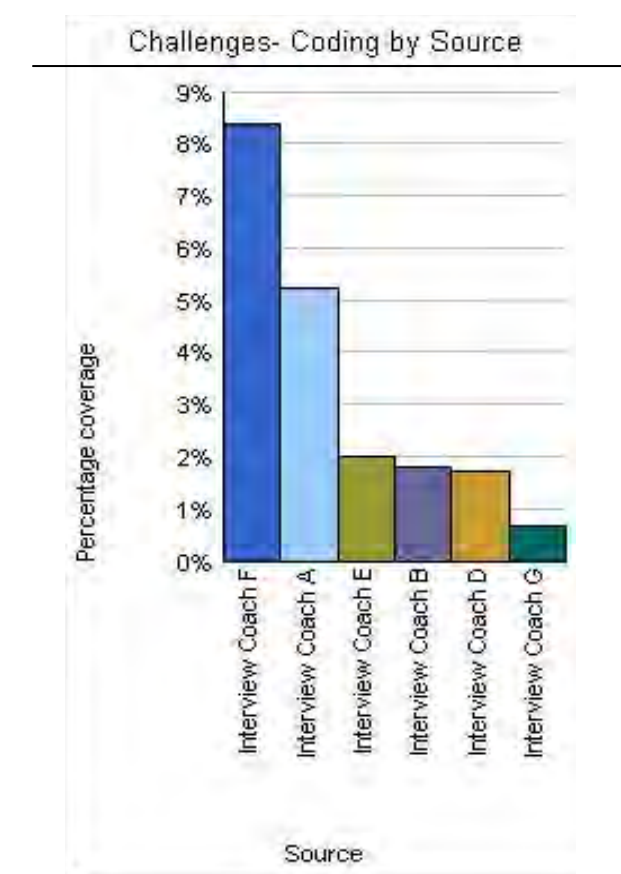
Coach F's dialog about challenges was eight and four tenths percent. She said:

> I don't think anybody can be a coach. I think it takes a person that you truly do want to help a patient. I think you have to have quite a few things at first, you need to be investigative we have to always wonder what's going through the patient's mind, how we can phrase things differently to help them. I think they need to try and imagine what it's like being at this patient's house because when they leave here it's totally different. We also have to kind of question, I guess inquisitive, we have to be inquisitive who helps them at home, who helps them with medications, do they have anybody? I think that if you're going to go to work and you're going to go and do your job and you leave at 5:00pm and you're done for the day, then a coach is not the kind of job you should have.

And:

> I feel like I am (challenged) because I think this clinic probably hasn't bought into the coaching thing. I do have a lot of doctors who are not at a totally 100% buy-in. So they'll do what I ask most of the time but I'm not sure if they've bought in. And here, too, when they have other doc meetings I haven't been invited to go to any of them so I don't know how they really feel. I hear that they really appreciate what I do, what the coach does, but as far as change. Change is big. Putting changes into a clinic is huge. Any time you have more than one person trying to make a change, it's not easy. Some things if it makes sense to them and if it makes money, they'd probably be easier to go through. I'm not saying what the coach says goes. Its uphill battles some of the time.

Coach D did not talk much about challenges but her comment helped to put into

perspective how far they felt they had come:

> Pretty much all of our doctors are pretty good now but it took a good year to get that buy-in from them. It really did because it's that perception of loss of control. Even though it's there to enhance what they're doing it's not in anyway to undermine their authority or their sense of control over what's happening. I think it's a perception thing. Once they realize that it's non-threatening, we're just here to help you guys out, then they really were more likely to relinquish some of that and say ok, if D says it's due, it's due.

Coach G also did not talk much about challenges but said:

> I think one of the biggest challenges we have is getting the rest of the staff to believe in what we're doing as much as we do. Buying into the health coach idea.

Summary of Analysis

The researcher had performed bracketing to check preconceptions before exploring the phenomenon of experiences of Physician Office Health Coaches as they delivered care to chronically ill patients within community clinics. Triangulation was another technique to enhance credibility. Triangulation was achieved by using multiple data sources in the study. Interviews with participants, observation of support meetings, and review of support documents, brought out the following:

1. POHCs spent time developing relationships with the patients.

2. POHCs advocated for patients.

3. POHC used motivational interviewing to assist patients in setting goals for self-management.

4. POHCs often were an extension of the doctor.

5. POHCs conducted chart review to maintain and update the disease registry.

6. POHCs educated patients and staff.

7. POHCs had a role as a change agent within the clinic.

8. POHCs were an information resource for all parts of the medical team.

9. POHCs perceived many challenges in their role.

The group of Physician Office Health Coaches the researcher interviewed and observed at support meetings, was passionate about their role and enthusiastic about their positive contribution to the functioning of the health team as it delivered care to patients.

CHAPTER V: DISCUSSION AND SUMMARY

Research Questions and Interpretation

The goal of this qualitative study was to develop theoretical insights that describe and explain the experiences of Physician Office Health Coaches as they seek to implement the Chronic Care Model. Data collection and analysis proceeded iteratively as collection and analysis on the first wave of interviews influenced the collection on subsequent interviews. The researcher attended health coach support meetings attended by all 15 coaches, from January to May 2008 and field observations supported interview themes. The POHCs were available by e-mail to collaborate and elaborate on the findings as all the interviewed coaches were present at the twice a month support meetings. Triangulation by combining field interviews with group meeting observations provided rich detailed data representative of the POHC experiences. An audit trail and member checking added trustworthiness and credibility. As themes emerged, further observations revealed minimal new information and therefore saturation was obtained. The researcher wanted to enhance awareness of the social dynamics in this unique clinical setting between the health coaches and patients. The social dynamic powerfully influenced the process of care and outcomes. As POHCs are conscious of the social factors at work, they can more constructively use them to assist patients in self-management, which in turn improves health and healing. By using the Transtheorectical Model of behavior change discussed in chapter two with motivational interviewing, POHCs can assist patients exploring ambivalence, move toward positive goal setting, and learn skills necessary for self-management of chronic disease. As the coaches became comfortable with relating to patients, they began to look at the role of "change agent" and sought opportunities to

improve clinic system flow to enhance the effectiveness of the healthcare team. The Transtheorectical Model can be applied to a wide range of behaviors where change is sought and people are in transition.

## Implications for the Profession

The IOM website (ICIC, 2008) explores new ideas and methods to deliver evidence-based care to chronically ill patients. The models and themes generated from this study describe how successful POHCs believe they are as they care for patients within primary care family medicine and internal medicine clinics. The POHC develops relationships with patients, advocates for evidence-based care, and acts as an extension of the physician. By using the tools of disease registries, previsit chart review, and seeking out community resources, they educate patients and staff.  The POHCs also feel challenges in their role as change agents but are passionate and devoted to the process of redesigning patient care to meet the needs of communities. The descriptions of their experiences help other POHCs understand the complex phenomena. It will provide ideas for other health coaches as they navigate similar social interactions and create relationships that nurture patients as they select a medical home and receive continuity of care instead of sporadic acute care. This will achieve the goal of continuous quality improvement.

## Limitations after Conducting the Study

This study was limited to one Midwest healthcare system at the time it had recently hired POHCs to work within their clinics. It is difficult to say if the findings of this study are transferable across the United States or internationally. It is important to note adding POHCs to a currently ineffective system will not produce the desired results.

The system must willingly undergo a redesign, which includes adopting Wagner's

Chronic Care Model. There needs to be agreement on clinical guidelines, physicians

giving up autonomy and working in teams, and use of disease registries.

Future Research

Future studies should explore the experience of patients who enter into

relationships with POHCs. Themes generated from this study could be tested in future

research to identify numerous self-management strategies used by patients or further

qualitative studies of the lived experience of people with chronic illnesses who have

access to an integrated health team which includes POHCs compared to those who do

not. As the POHC position is relatively new and emerging, a duplication study that

includes interviewing of health coaches after more time in their position will solidify the

skill set needed to be successful and therefore give insight into potential inclusion into

future curricula for health care professional education.

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Appendix A

**MERCY CLINICS, INC.**
**JOB DESCRIPTION**

**TITLE**: Population Health Coach                    **FLSA STATUS**: Non-exempt

**DEPARTMENT**:  Mercy Clinics, Inc.                    **JOB CLASS**: 4030

**GENERAL SUMMARY**:
Assists physician and clinical staff with clerical/clinical functions for patients requiring chronic disease coordination.  Is accountable to the Clinic Manager or Medical Director. Works closely with the Quality Committee as well as the Vice-President of Quality and the Clinic Director of Quality Improvement.

**CORPORATE PHILOSOPHY STATEMENT**:
It is the obligation of each employee of Mercy Clinics, Inc. to abide by and promote the mission and core values of the Spirit of Mercy.

**CORPORATE POLICY STATEMENT:**
It is the obligation of each employee of Mercy Medical Center to comply with Mercy's mission, values, standards of conduct, policies, procedures, and related practices (e.g., Dress Code, Time and Attendance, and other policies).

**HIPAA SECURITY COMPLIANCE:**
**Security Access:  High** "Incumbent has access to restricted or confidential patient information and must comply with the terms of the Mercy Medical Center Security Policies as it applies to their job role."

**ESSENTIAL FUNCTIONS**:
- Assists and coordinates various functionality and utilization of disease registry database including data entry; assuring database is kept up to date; identifying patients overdue for visits, labs, or referrals; identifying patients not meeting clinical goals; and creating patient, physician, and clinic level quality performance reports.
- Proactively contacts patients to arrange follow-up on process or outcome goals that registry queries show are not being met.
- Conducts pre-visit chart review to identify all needed preventive health maintenance, immunizations, and chronic disease interventions.  Needed interventions will be communicated to providers or ordered by protocol.
- Makes referrals as ordered by providers or by protocol.
- Educate patients about the Mercy Clinic's chronic care program and the importance of meeting their goals and assists with goal setting and plans for behavior change.

- Meets on a regular basis with other MCI Population Health Coaches and Population Health Nurses, as coordinated by Clinic Administration, for information sharing and continuing education activities.
- Assist with clinic QI activities.
- Types correspondence (memos and letters), statistical forms and procedures and is able to maintain complete patient records while keeping complete patient confidentiality.
- Demonstrates effective organizational skills.
- Maintains confidentiality of patient, personnel, and institutional information.
- Maintains current professional knowledge and competencies.
- Demonstrates professional, appropriate, effective and tactful written, verbal, and nonverbal communication with patient, families, medical staff, colleagues, vendors, and other departments throughout the continuum of care to promote continuity of care and services and enhance clinic image.
- Acknowledges patient's rights on confidentiality issues, maintains patient confidentiality at all times, and follows HIPAA guidelines and regulations.
- Participates in staff development activities and orientation as requested
- Demonstrates positive professional customer service in all patient, staff, and visitor contacts
- Utilizes interpersonal skills to establish and maintain healthy interpersonal relationships with healthcare members, patients, and families.
- Proactively acts as a patient advocate, responding to and working to resolve patient concerns.

**MARGINAL FUNCTIONS**:
- Answers and routes multiple telephone calls and faxes, takes and directs messages and information pertinent to chronic disease management. Receives and arranges appointments for providers and patients for patient meetings, procedures, and appointments and sends correspondence as designated.
- Miscellaneous office duties such as greeting patients, answering phone, filing and/or retrieving medical records, and scheduling patient appointments.
- Assists with the clerical operation of office equipment (PC/word processor, CRT, printer, typewriter, copy machine and fax) to effectively and efficiently perform secretarial duties for management purposes.
- Inventories, orders and receives office supplies and printed materials. Maintains general files and supplies.

**MINIMUM KNOWLEDGE, SKILLS AND ABILITIES REQUIRED**:
- Post high school clinical health-related degree or certification required (i.e. CMA, RN, LPN, BA or BSN). Three years of medical experience or equivalent background with a strong understanding of the medical field preferred.
- Knowledge of and practical use of good business English, spelling, arithmetic, practices and the ability to communicate effectively using written and verbal skills.

**PHYSICAL ACTIVITY REQUIREMENTS:** **(Constant = 67-100% of work day, Frequent = 34-66% of work day, Occasional = 33% of work day)**

**Constant**: Talking: Expressing or exchanging ideas by means of the spoken word to convey information to co-workers, patients, visitors, etc.

Hearing: Ability to receive detailed information through oral communication from others in person or on the telephone.

Fingering: Picking, pinching, typing or otherwise working, primarily with fingers rather than with the whole hand or arm while typing.

Seeing: Ability to view for reading patient information, correspondence, computer terminal, instructions, etc.

**Frequent**: Repetitive Motions: Substantial movements of the wrists, hands, and/or fingers during typing, writing, filing, etc.

Grasping: Applying pressure to an object with the fingers and palm while picking up supplies, telephone, etc.

Reaching: Extending arm(s) and hand(s) to obtain needed items and during filing of cine films and folders.

Walking: Moving about on foot to accomplish tasks.

Stooping: Bending body downward and forward by bending spine at the waist to obtain supplies and to file.

Kneeling: Bending legs at knee to come to a rest on knee or knees during filing.

Pushing: Using upper extremities to press against something with steady force in order to thrust forward, downward, or outward while moving objects such as file drawers and supplies.

Pulling: Using upper extremities to exert force in order to draw, drag, haul, or tug objects while opening supply boxes and file drawers.

Lifting: Raising objects from a lower to a higher position or moving objects horizontally from position-to-position.

**Occasional**: Ascending or descending a short step stool using feet and legs and/or hands and arms to reach patient records on higher shelves.

**PHYSICAL DEMAND REQUIREMENTS**:
Light Work: Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly to move objects.
**VISUAL ACUITY REQUIREMENTS**:
Work involves preparation and analysis of data, keyboard entry and extensive reading of pertinent literature.

**INTELLECTUAL/EMOTIONAL REQUIREMENTS**:
- Adaptability to performing a variety of duties, often changing from one task to another of
  a different nature without loss of efficiency or composure.
- Adaptability to situations involving the interpretation of feelings, ideas, or facts in terms of personal viewpoint.
- Adaptability to influencing people in their opinions, attitudes, or judgments about ideas or things.
- Adaptability to making generalizations, evaluations, or decisions based on sensory or judgmental criteria.
- Adaptability to making generalizations, evaluations or decisions based on measurable or verifiable criteria.
- Adaptability to dealing with people beyond giving and receiving instructions.
- Adaptability to performing under stress when confronted with emergency, critical, unusual, or dangerous situations; or situations in which working speed and sustained attention are make-or-break aspects of the job.
- Adaptability to accepting responsibility for the direction, control, or planning of an activity.
- Adaptability to maintain both a high standard of courtesy and cooperation in dealing with co-workers, patients and visits with satisfactory job performance despite the stress of a medical work environment.

**TOOLS/EQUIPMENT**:
- \* Typewriter          \* CRT/Printer
- \* PC/Word Processor    \* Copy Machine
- \* Telephone            \* Fax

**WORKING CONDITIONS**:
- Employees in this job classification have been identified as likely to be exposed to blood or other potentially infectious materials.

**REPORTING RELATIONSHIPS**:
- Direct Reports to Clinic Manager or Medical Director
- Indirect Report to MCI Clinic Director of Quality Improvement

*The above is intended to describe the general content of and requirements for this job. It is not intended to be a complete statement of duties*

Appendix B

**Mercy Clinics, Inc.**
A member of Mercy Medical Center Des Moines

Patient Name: _____

Date: _____

## Self-Management Support – 5A's

**Agree**   To an agenda - what does the patient want to work on?
   *Patient Goal: _____

| **Assess** | **READINESS** to Change | ❑ Not ready | ❑ Unsure | ❑ Ready |
|---|---|---|---|---|
| | **IMPORTANCE** in relation to other values | ❑ Low | ❑ Medium | ❑ High |
| | **CONFIDENCE** of success | ❑ Low | ❑ Medium | ❑ High |

**Advise**   What would the patient like to talk about?_____
   Information exchanged (elicit-provide-elicit):

**Assist**   Patient to develop a personal action plan (if patient is ready).

> | **Dealing with resistance** | • Emphasize personal choice and control |
> |---|---|
> | | • Reassess importance, confidence, readiness |
> | | • Do not confront resistance with force – use reflective listening |

   1.  Options for behavior change (usually there are many possible courses of action)


   2.  Patients preferred option: _____

   3.  Are there barriers the patient needs help with (depression)?


   4.  Follow up plan - When : _____     How:  ❑ Phone_____  ❑ Other _____

                                          Educator Signature:_____

**Arrange:** to contact the patient between visits.

   ***Follow-up Contact:***   Completed on - Date:_____

   1.  Results of behavior changes

   2.  Barriers encountered (if any)

   3.  Preferred option for new plan


   4.  Follow up plan - When : _____     How:  ❑ Phone_____  ❑ Other _____

Follow-up Signature:_____

*Required to bill Wellmark (Individual visit - S9445)

Appendix C

## PDSA Worksheet for Testing Change



**Aim:** (overall goal you wish to achieve)

*Every goal will require multiple smaller tests of change*

**Plan**

| Describe your first (or next) test of change: | Person responsible | When to be done | Where to be done |
|---|---|---|---|
|  |  |  |  |

| List the tasks needed to set up this test of change | Person responsible | When to be done | Where to be done |
|---|---|---|---|
|  |  | . |  |

| Predict what will happen when the test is carried out | Measures to determine if prediction succeeds |
|---|---|
|  |  |

**Do**   Describe what actually happened when you ran the test

**Study**   Describe the measured results and how they compared to the predictions

**Act**   Describe what modifications to the plan will be made for the next cycle from what you learned

Institute for Healthcare Improvement

Form available on http://www.mercydesmoines.org?Quality/QualityIndex.htm

Appendix D

# Conversation Flow

1. Open the conversation
   - Name
   - Role
   - Time
   - Ask permission

2. Ask open-ended questions
   - Invites client to do most of the talking
   - Focus on strengths & successes

3. Negotiate the agenda
   - Supports autonomy and choice
   - Facilitates conversation
   - Less is more!

4. Assess readiness to change
   - Supports tailoring
   - Invites "change talk"

5. Explore ambivalence
   - Most common stage of change
   - Needs to be addressed for sustain
   - Invites "change talk"

6. Ask about "next step"
   - Assesses impact of conversation
   - Perspective often shifts in the process!

7. Close the conversation
   - Show appreciation
   - If appropriate, offer recommendation
   - Voice Confidence

**Invite and encourage "change talk"**

*Ask*          *Listen*          *Summarize*

Adapted from Miller and Rollnick. 1991-2002

Appendix E

# **Application for Research Approval**
College of Saint Mary
Institutional Review Board

***Before submitting the application, the researcher must determine whether a full review or exempt review is required by consulting CSM's IRB Guidelines, available from the IRB chair. The researcher must also follow the guidelines for submitting this Application, as outlined in the IRB Guidelines.***

_____ Full Review                 __X__ Exempt Review

I. Purpose of the Study. Briefly identify the specific aim of the research – why is the research being conducted?

   The purpose of this study is to explore the perceived value of Population Health Coaches' self-described role as the implement the Chronic Care Model within a primary care setting in the Midwest.

II. Background and Rationale (Full Review only). What is the background and scientific rationale for the study? Include literature citation if relevant.

III. Number of Participants Expected.

   Up to 15 Health Coaches will be interviewed for up to three times with each interview lasting no longer than one hour.

IV. Characteristics of Participants. What are the specific inclusion criteria for participation? If there are participation restrictions (e.g., gender, race, religion, age, etc.), provide rationale as to why these restrictions are necessary.

   The Health Coaches are employed by Mercy Clinics Incorporated and therefore are all over the age of 18 and are either RNs, CMAs or LPNs. There are no other restrictions.

V. Method of Participant Recruitment.

   I have contacted the Quality Improvement Committee of Mercy Clinics Inc. and the director has purposefully selected Health Coaches for interview.

VI. Study Site(s). Where will the study be conducted?

   Health Coaches will be interviewed in at their clinics in their office at a time that is convenient for them and their clinic.

VII. Description of Procedures (Full Review only). Identify exactly what participants will be doing in your study, as well as what will be done to participants. Identify all procedures, including audio or video recording, or observation of the participant.

VIII. Confidentiality. Address how data will be kept confidential. Will any identifiers be used to specifically link data to an individual participant? If so, provide justification as to why identification of individuals is necessary.

All interviews will be transcribed at the time of transcription names will be removed and codes assigned.  The code sheet will be retained by the investigator and kept in a locked file cabinet within a locked office. After analysis the audiotapes will be destroyed as well as any electronic copies of the audiotapes.

IX.   Informed Consent (Full Review only). The form should include full disclosure of the study. See Informed Consent Guidelines for full information.

Appendix F



April 25, 2008

Janet Roberts-Andersen
College of Saint Mary 7000 Mercy Road
Omaha NE 68106

Dear Janet,

The Institutional Review Board at College of Saint Mary has granted approved of your request, **"Role of Population Health Coaches in Chronic Disease Management was approved,"** at the April 14, 2008 meeting.  The Committee has assigned approval number CSM 08-13.  The approval expires in one calendar year, April 25, 2009.

Attached is the "Rights of Research Participants" document.  You are required to give each IRB research participant a copy of the document.  Congratulations on your IRB approval and best wishes as you conduct your research!

Sincerely,

*Peggy L Hawkins, PhD, RN, BC, CNE*

Peggy L. Hawkins, PhD, RN, BC, CNE
Professor
Chair, Institutional Review Board

IRB # CSM 08-13
Date Approved April 25, 2008
Valid Until:  April 25, 2009

7000 Mercy Road • Omaha, NE 68106-2606 • 402.399.2368 • FAX 402.399.2654 • www.csm.edu

Appendix G

# COLLEGE OF SAINT MARY

**THE RIGHTS OF RESEARCH PARTICIPANTS\***

**AS A RESEARCH PARTICIPANT ASSOCIATED WITH COLLEGE OF SAINT MARY YOU HAVE THE RIGHT:**

1. TO BE TOLD EVERYTING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.

2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.

3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.

4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.

5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.

6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.

7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.

8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

**THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400.**
**\*ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER , IRB WITH PERMISSION**

7000 Mercy Road • Omaha, NE 68106-2606 • 402.399.2400 • FAX 402.399.2341 •
www.csm.edu

Appendix H
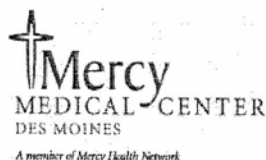
**Mercy**
MEDICAL CENTER
DES MOINES
*A member of Mercy Health Network*

## Mercy Medical Center – Des Moines
## Institutional Review Committee

### Waiver of Consent Application

Preparing Waiver of Consent Application

1. Please submit a typewritten and completed application.
2. If the Primary Investigator is a resident or trainee in a program sponsored by a constituent entity of Mercy Medical Center then this application must be sponsored by a Program Director or Faculty Member who will be held to the same Assurances as the Primary Investigator. Please lest the Faculty Sponsor as a Sub-Investigator.
3. Waiving informed consent for research must satisfy **ALL** of the conditions listed in the Federal regulations for Protection of Human Subjects, 45 CFR 46, and Standard for Privacy of Individually Identifiable Health Information (a.k.a. HIPAA), 45 CFR 164.512. These conditions are:
   a. The research involves no more than minimal risk to the subjects;
   b. The waiver or alteration will not adversely affect the rights and welfare of the subjects;
   c. The research could not practicably be carried out without the waiver or alteration; and
   d. *Whenever appropriate*, the subjects will be provided with additional pertinent information after participation.
4. Anyone listed on this application is required by Federal Regulations and IRC policy to have completed Human Research Protection Training. This can be obtained through the NIH or CITI website, PRIM&R 101 or 250, or VA Medical Training.
5. This application will not be processed if not completed. This could result in your trial being tabled.

**To move through this document, please keep document "locked" and use "Tab" key.**

**Please forward documents**
Mercy Medical Center – Des Moines
Institutional Review Committee
1111 6th Avenue
Des Moines, IA 50314
(515) 247-3985 (office)
(515) 643-8986 (fax)
dburns@mercydesmoines.org

†Mercy
MEDICAL CENTER
DES MOINES
*A member of Mercy Health Network*
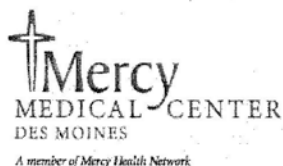
**Institutional Review Committee**
Waiver of Consent Application

## 1. Project Information
PLEASE PROVIDE ALL REQUESTED INFORMATION

Principal Investigator:     Janet Roberts-Andersen

Site:    Mercy Clinics, Inc and Mercy College

Name of Study: (Full Title)    The Role of Physician Office Health Coaches in Chronic Disease Management

Primary Investigator:     Janet Roberts-Andersen

Sub-Investigator      Sub-Investigator:
Sub-Investigator      Sub-Investigator
Sub-Investigator      Sub-Investigator

Do all Investigators participating in this trial have privileges to perform the procedures described in the protocol at Mercy Medical Center or any of its affiliates?    ☒ Yes   ☐ No

Have all Investigators received training in Human Research Protection Training?    ☒ Yes   ☐ No

## 2. Data Collection
CHECK ALL THAT APPLY

Please mark all boxes of information that will be collected as part of the study data.

| | | | |
|---|---|---|---|
| ☐ | Name | ☐ | Telephone Number |
| ☐ | Social Security Number | ☐ | Account Numbers |
| ☐ | Fax Numbers | ☐ | Medical Record Numbers |
| ☐ | Full face photographic images | ☐ | Date of Birth |
| ☐ | Health plan beneficiary numbers | ☒ | Other *(specify):* Interviews assigned unique number not associated with interviewees name |

## 3.  **Regulation Requirements**
PLEASE PROVIDE ALL REQUESTED INFORMATION

| 1. | State why the research involves no more than minimal risk to the participants<br>The prinicple investigator has no relationship with interviewees and has no influence over employment status. |
|---|---|
| 2. | State why the waiver or alteration will not adversely affect the rights or welfare of the participants.<br>Interviewees are voluntary and withdraw at any time. |
| 3. | State why the research could not practicably be carried out without the waiver<br>Qualitative indepth interviews need to be done face to face to gather the whole experience of the interviewee. |

## 4.  **Protection of Patient Identifiers**
PLEASE PROVIDE ALL REQUESTED INFORMATION

| 4. | Summarize the plan to protect identifiers from improper use and disclosure<br>Priniple investigator will assign code number only known by the principle investigator.  The code list is kept in a locked file cabinet in a locked private office. |
|---|---|
| 5. | Summarize the plan to destroy the identifiers at the earliest opportunity consistent with the conduct of research, unless there is a health or research justification for retaining the identifiers or is otherwise required by law.<br>As soon as audio tapes are transcribed and varied for themes, the tapes are destroyed. |
| 6. | Summarize the written assurances that PHI (Personal Health Information) will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project.<br>No other personal data is collected besides the interviewee's code number. |
| 7. | Summarize how the identifiers will be destroyed.<br>All audio tapes and computer files will be destroyed after completion of the dissertation May 2009. |

Appendix I

# Mercy
## MEDICAL CENTER
### DES MOINES

*A member of Mercy Health Network*

IIII 6th Ave.
Des Moines, IA 50314-2611
515-247-3121

April 9, 2008

Janet Roberts-Andersen
Mercy College of Health and Science

**RE: Physician Office Health Coaches – Waiver of Informed Consent Application – Receipt
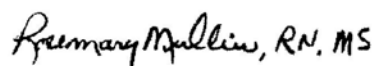Study ID#: MMC2008-006**

Dear Janet,

The Institutional Review Committee has received your Application for Waiver of Consent for the following trial:

**The Role of Physician Office Health Coaches in Chronic Disease Management**

This trial is research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation or quality assurance methodologies. This application also meets the criteria of Waiver of Consent set forth in § 45 CFR 46.116(d) therefore; this application will be submitted for expedited review.

This IRC operates in accordance with all local and federal applicable laws, regulations, and guidelines for research. Compliance is maintained with the FDA Code of Federal Regulations, Office for Human Rights Protections (OHRP), Good Clinical Practice (GCP) guidelines, and International Conference of Harmonization (ICH). All documentation is maintained in the study file per FDA/DHHS Regulations and IRC Guidelines.
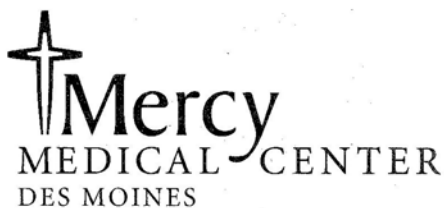
Sincerely,

*Rosemary Mullin, RN, MS*

Rosemary Mullin, RN, MS
Vice-Chair, Mercy IRC

RM/ddb

Appendix J

# ✝Mercy
## MEDICAL CENTER
### DES MOINES

*A member of Mercy Health Network*

1111 6th Ave.
Des Moines, IA 50314-2611
515-247-3121

May 16, 2008

Janet Roberts-Andersen
Mercy College of Health and Science

**RE: Physician Office Health Coaches - Committee Notification**
**Study ID#: MMC2008-006**

Dear Janet,

On 5/16/2008 the Institutional Review Committee was informed of your Application for Waiver of Informed Consent approval for the above-mentioned protocol.

The committee was informed that this study is a research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation or quality assurance methodologies study and involves no more than minimal risk, the waiver will not adversely affect the rights and welfare of the subjects, and the research could not practicably be carried out without the waiver.

Should you have any further questions regarding this notification, please feel free to contact the IRC office at 247-3985.

This IRC operates in accordance with all local and federal applicable laws, regulations, and guidelines for research. Compliance is maintained with the FDA Code of Federal Regulations, Office for Human Rights Protections (OHRP), Good Clinical Practice (GCP) guidelines, and International Conference of Harmonization (ICH). All documentation is maintained in the study file per FDA/DHHS Regulations and IRC Guidelines.

Sincerely,

*Rosemary Mullin, RN. MS*

Rosemary Mullin, RN MS
Vice-Chairman, Mercy IRC

RM/ddb

Appendix K

# Mercy
MEDICAL CENTER
DES MOINES

*A member of Mercy Health Network*

April 9, 2008

Janet Roberts-Andersen,
Mercy College of Health and Science

**RE: Physician Office Health Coaches – Waiver of Consent – Approval**
**Study ID#: MMC2008-06**

Dear Janet,

On 4/9/2008 I exercised my right, as IRC chairman, to expedite the Application for Waiver of Informed Consent for the following trial:

**The Role of Physician Office Health Coaches in Chronic Disease Management**

It is understood that this study is research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation or quality assurance methodologies. This application does falls within the guidelines of § 45 CFR 46.116(d) that states that this research involves no more than minimal risk, the waiver will not adversely affect the rights and welfare of the subjects, and the research could not practicably be carried out without the waiver.

Since this research has been granted Waiver of Consent an annual renewal will not be required. In the future, you will be asked to submit an annual summary letter to update the committee on the progression and information that has been collected. Should you complete your medical record review and all publications or presentations, before your annual summary can be submitted, *you will need to submit your findings in a Final Report to the committee.*

This study has been assigned the number **MMC2008-006**. This number needs to be used in **ALL** correspondence between this site and the IRC office.

This Application for Waiver of Consent will be included on the Agenda for the **5/16/2008** IRC meeting for notification to the full committee.

Should you have any questions regarding this approval letter, please feel free to contact our offices at (515) 247-3985.

This IRC operates in accordance with all local and federal applicable laws, regulations, and guidelines for research. Compliance is maintained with the FDA Code of Federal Regulations, Office for Human Rights Protections (OHRP), Good Clinical Practice (GCP) guidelines, and International Conference of Harmonization (ICH). All documentation is maintained in the study file per FDA/DHHS Regulations and IRC Guidelines.
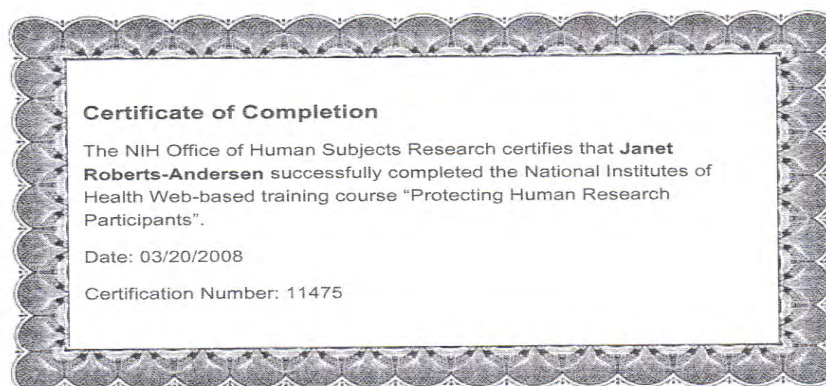
Sincerely,

*P Palakurthy*

Prasad Palakurthy, M.D.
Chairman, Mercy IRC

PP/ddb

Appendix L

Protecting Human Subject Research Participants

**Certificate of Completion**

The NIH Office of Human Subjects Research certifies that **Janet Roberts-Andersen** successfully completed the National Institutes of Health Web-based training course "Protecting Human Research Participants".

Date: 03/20/2008

Certification Number: 11475

http://phrp.nihtraining.com/users/certificate.php                    3/20/2008

Appendix M

Research Interview Questions-

Interview protocol: **The Role of the Physician Office Health Coach from the Coach's Perspective**

Date/Time of Interview _____ Place _____

Interviewee _____ time they have been a POHC_____

Describe the room the interview took place in _____

1. Describe for me the role of the Health Coach as you see it.

2. What do you like about being a health coach?

3. How did your previous education prepare you for this position?

4. How effective do you think the Health Coach is in changing target behaviors?
   a. How do you help patients set their action plan?
   b. How do you seek out their preferences and readiness?
5. What is the average time you spend with a patient?

6. How do you get new information to pass on to patients?
   a. How do you link them up with community resources?

7. How do you see the health care team functioning in the redesign?

8. Is there anything you would like to add that would help me understand the Health Coach better?

Field Notes

| Descriptive Notes: | Reflective Notes: |
|---|---|
| **Date/Time :**<br>Setting: | |
| | |
| | |
| | |
| | |
| | |
| | |
| Layout of the interview room | |